IDENTITY, PLACE AND HEALTH REFORM: A CASE STUDY OF NURSES' PROFESSIONAL IDENTITY IN A NEW ZEALAND TOWN

A thesis
submitted in partial fulfilment
of the requirements for the Degree
of
Master of Arts in Feminist Studies
in the
University of Canterbury
by
Lee Thompson

University of Canterbury
2001

CONTENTS

ABSTRACT

Identity, Place and Health Reform: A Case Study of Nurse's Professional Identity in a New Zealand Town

This research is a critical study of small town nurses in light of the recently introduced market model in health management and services. I examine the professional identity of Registered Nurses by looking at how this newly defined 'market worker' negotiates a place within the discourses of restructuring and the quasi-rural town. Among the new challenges for nurses faced by restructuring are the issues of flexibility and mobility.

Reform in the health sector in New Zealand has resulted in the scaling down, and in some cases closure, of hospital facilities in towns. Some types of nursing work in towns are no longer practiced resulting in de-skilling, particularly in the area of surgical nursing. The remaining jobs, however, encompass multiple skills, and thus require functionally flexible or multiskilled staff.

It is argued that global processes, such as a shift to a market economy and restructuring are affected by place and hence differentially experienced by people in different locales. Small towns, for example, can be seen as a site of marginality in national and global terms and this in turn shapes the employment structure for nurses. Thus town nurses are more likely to be marginalised in a hierarchy which privileges highly specialised and high technology city nursing as opposed to low technology and functionally flexible or multiskilled town nursing.

In this research paper I argue that factors such as de-skilling, a shift to multiskilling and a recent loss of pay and work conditions in a small New Zealand town contribute to a crisis in professional identity among nurses. This crisis gives rise to several responses, for example, the proposal to either shift or commute for alternative nursing work (mobility), or to leave nursing altogether. 'Choices' surrounding paid work, even when a professional identity seems to be under threat, are seen to be highly contingent and the negotiation process of enabling and constraining discourses often eventuates in adjustment to the status quo.

INTRODUCTION

Nursing in New Zealand, as in other parts of the world, has in the last twenty or more years undergone some of its most radical changes. The push to professionalise nursing has given rise to a process of increasing credentialism. At the same time, shifts in medical treatment have seen the introduction of lower rates of hospitalisation and shorter hospital stays. The demographic trend towards an aging population has also had an impact on health care needs and costs. Along with these shifts has been the introduction and intensification of the principles of a market driven economy. One effect of the 'more market' principles has been radical restructuring of social services such as health and education.

The process of restructuring the health sector has not happened as an isolated event, but rather began as part of a wider move to restructure the entire New Zealand economy. This shift was prompted by several very significant international moves which 'shocked' the New Zealand economy in the 1970s[1]. Coupled with these international moves, rising inflation and increasing levels of unemployment nationally, prompted a radical response on the part of the new 1984 Labour government. The policies enacted by this government promoted (among other things) the primacy of a deregulated market as a key to New Zealand's economy becoming internationally competitive. Along with more-market policies, were also explicit initiatives to "roll back the state" (Kelsey 1993), and thus fulfil the neo-liberal objective of a "minimalist state" (Larner 1998: 5)[2].

These policies were presented to the population of New Zealand as the *only* alternative to an unhealthy economic situation[3]. In this regard, Brodie suggests that

---

[1] According to Dalziel and Lattimore these 'shocks' consisted of firstly: the entry of Britain into the EEC (which negatively affected the ready market New Zealand had enjoyed for wool, meat and dairy products). Secondly; a hike in the price of oil (1996: 15-18).

[2] Larner (1998a: 12) makes the important distinction between 'government' and 'governanace' and suggests that less government does not necessarility mean less governance.

[3] Tim Hazeldine, somewhat flippantly calls this TINA, or; There Is No Alternative! Many authors have since challenged this overriding notion that there was no alternative. See Hazeldine. 1998, Kelsey. 1993, 1997, Dalziel. 1992, 1996, for instance.

the "restructuring discourse attempts to depoliticize the economic by representing market-driven adjustment as self-regulating and inevitable" (1996: 388). The focus on the inevitability of 'market-driven adjustment' has been part of the rhetoric which has paved the way for the government to push through sweeping, and cumulative changes very rapidly. This rapidity has led Barnett (1999: 4) to suggest that the process has been undemocratic. Further, Blank (1994) argues that the pace of reform, especially in the health sector, left little time between successive rounds of restructuring to test the new system for efficacy.

The impact of restructuring on rural New Zealand, particularly agriculture and farming, where many of the subsidies that had protected these producers from the vagaries of the market have been lost, is well documented (see, for instance, Kelsey 1997: 95-96; Le Heron and Pawson 1996). Industries located in minor urban areas have been faced with the prospect of closure or relocation in order to find even cheaper sources of labour to maintain profit margins in the new, highly competitive, economic climate. Towns have been affected in at least two ways; firstly, by the flow on effects from the lowered returns of the agricultural and farming sectors and secondly, from the restructuring of the service sector in general. Institutions such as the Post Office, Banks, and branches of social support agencies have been restructured which has often resulted in their withdrawal from towns[4].

While there was much external support for the reform process in New Zealand, the reality within the country was that many saw the reform process (which was initially supposed to be short and painless) as rather tortuous and painful. Britton et al., for example, argue that too little attention has been paid to the human costs of this, now lengthy, change process:

> It is easy to feel over the last few years little consideration has been given by policy makers to the ways in which restructuring has impacted upon people's everyday lives. The greatly changed circumstances in which all find themselves have inevitably challenged our senses of place: what it means to live in this country and indeed what it means to be New Zealanders. The securities of existence in familiar localities, in a country with seemingly stable

[4] Kearns and Joseph note that although loss of services and population decline have been part of rural communities since the end of the second world war, the rate of decline has sped up since the mid 1980s with restructuring inititiatives (1997: 21).

> patterns of internal and external relations, have been irrevocably changed. (Britton et al. 1992: 267)

Indeed, it is crucial to look broadly at restructuring, going beyond purely economic costs. In addition, the question of human cost resulting from the process of restructuring is inseparable from how people's subjectivities are constructed. As Larner suggests:

> the 'discourse of restructuring' [Larner following Yeatman 1990] refers not simply to the rhetoric of hegemonic political-economic groups, but rather to the complex system of meaning that constitutes institutions, practices and social subjectivities in contradictory and disjunctive ways. (1998b : 266)

The process of health restructuring has coincided with the rise of the service sector as a major employer. As Christopherson (1989) notes, there may be a masculinist bias in contemporary discussions of economic restructuring since there is an "excessive amount of attention dedicated to restructuring within manufacturing industries, excessive because most job growth and much job restructuring has occurred within the service sector" (cited in Hanson and Pratt 1995: 10). At this point, I should like to add that the "masculinist bias" is also at work when considering the relative marginalisation of nurses within the service sector.

It is remarkable that so many works discussing health, hospitals, medical care or restructuring of health services tend, in the main, to ignore nurses who are usually one of the biggest if not the biggest occupational group within health care. In March 1999, for instance, there were 31,869 registered nurses and midwives in active practice in New Zealand[5] and 94.3 percent of nursing and midwifery professionals were female (Statistics New Zealand 1998: 96). Unlike the concern focussed on doctors[6] little attention is paid to nurses; it is almost as if they are a taken for granted workforce. As Halford et al. note; "nursing has been largely ignored in academic evaluations of restructuring, reflecting and indeed reinforcing the lesser influence and power of

[5] These figures were gained from a personal correspondence with the registrations adviser of the Nursing Council of New Zealand.

[6] It is interesting to note that in August of 1999 junior doctors are striking over issues of pay rates. They are concerned that with mounting student debt they are better to become mobile and go overseas given the better earning potential there. Nurses also incur student debt and given the differential in their earnings, I wonder if their situation is so very different. In fact there is also concern about the number of nurses going overseas but the media attention is not so great.

nurses as an occupational group" (1997: 91). What is also ignored or absent in empirically based research studies is the position and positioning of nurses in small New Zealand towns.

Just as nurses are argued to be on the whole, marginalised, the 'town' is also positioned in a marginal frame. In fact, towns under health restructuring are under represented in the literature. Significantly, towns are more vulnerable to the changes associated with restructuring due to the relatively small economic base with which they work. Against the privileged position held by large urban centres, towns are often seen to be parochial, marginal and of little importance in a globalising economy. Nurses, who are already marginal compared to doctors, are even less visible if they happen to live in towns. Thus 'place' as a parameter, as a context, as an embedded category is argued to matter. That is, the significance of place is seen to be vital to an understanding of the way that negotiations are played out under restructuring with regard to nurses (gender) and paid work.

Since the purpose of this study is to address the marginalisation of both place and nurses, the focus of this work is on Registered Nurses[7], rather than on health care workers more generally. The issue of nurses' professional identity is explored ideologically and materially in the context of the restructuring health service. Nurse's experiences are seen to be embedded in the context of the town, the family and professional ideology.

The changes that nurses in towns have experienced have had a major impact on their jobs. Over the last ten to fourteen years, not only has the overall number of jobs decreased due to hospital downsizing, but the content of the jobs has also changed with the withdrawal of surgical services[8]. Incidentally, the hospital in question in this thesis serves a population of between twenty one and twenty two thousand people in

[7] The term Registered Nurse refers to a person who has completed a three year training program and has been admitted to the register of nurses.

[8] The restructuring of the health sector has seen the introduction of 'efficient', rationalised, market driven strategies. The implementation of these policies has resulted in the closure or downsizing of some rural/town hospitals, with concomitant centralisation of specialist services in larger centres.

the town and its surrounding area and is located in the South Island of New Zealand. This particular hospital has lost surgical services and has downsized considerably.

Alongside the downsizing of the hospital and the loss of surgical services, there has been a concentration of most of the hospital's patients into one, all-purpose hospital ward. The act of placing most patients in one ward in this way has altered the role of the nurses who work there. Nurses in this mixed type of work setting need to be multiskilled in order to meet the needs of a wide range of patients in one ward. While nurses receive a general training, most end up practicing as specialists of some sort, and hence the potential for tension between professional and managerial requirements is intensified. This transition from low[9] levels of specialisation, as compared with the degrees of specialisation which are still practiced in city hospitals, towards multiskilling can in some ways be seen to be an attempt to reconstruct many town nurses' professional identity. As I shall argue here, the situation is very complex and the requirements of multiskilling should not be taken lightly. Multiskilling has been promoted as an enlargement of the professional role and a positive move; yet questions need to be asked about who defines multiskilling and how it is quantified (if indeed it can be), and how a nurse maintains the skills required to practice in a multiskilled environment. What multiskilling means in practice remains under-explored.

In a restructured health service (scaled down, rationalised, multiskilled and flexible), there are, inevitably, discontents with some of the changes. Amongst the most recent of these changes has been a drop in pay and working conditions for nurses and some uncertainty regarding job security. These changes can be seen to challenge the very notion of nurses' professional identity and the tension and confusion that result may mean that many consider quitting, relocating or commuting for alternative nursing work.

[9] The 'low' levels of specialisation referred to here consist mainly of specialisation into either medical and surgical areas.

Commuting or relocating for work are actions which may play a larger part in household decision making now than they have in the past. This is especially the case with regard to women's work which, traditionally, has not been a stimulus to mobility. In fact there is a whole raft of enabling and constraining factors which influence this decision-making process. Amongst these are debates around commitment to paid work, the presence and ages of children, presence and age of partners, attachment to place and personal health issues. Although many nurses have explored their options regarding relocating or commuting for alternative nursing work, the majority remain where they are.

In order to provide a depth of context to this thesis the first three chapters provide a literature review and theoretical frameworks that are deemed relevant to the analysis of the situation in which town nurses find themselves. Chapter one introduces the processes of restructuring and specifically of health restructuring in New Zealand and argues for the importance of considering the notion of place/locale in an analysis of politics and power relations. The notion of the town as a marginal site is explored. Chapter two explores the positioning of women in paid work, both historically and in the present, paying attention to the debates around the notions of public and private. Following on from this, the ways in which nursing has been constructed are investigated, paying particular attention to the conundrum of care work. Looking at women and work in general and nurses and work in particular enables a contextualisation of the identity which women/nurses bring to paid work. Chapter three introduces management as the conduit through which government policies of restructuring are implemented. It also looks at the ways in which management has changed. The strategy of flexibility, promoted under restructuring and actioned by management is identified and explored. Flexibility in the form of mobility is also introduced in this chapter. The dynamics for women in terms of mobility are discussed and draw us into the tensions between home and paid work, and from there to commitment to paid work. Chapter Four discusses the research strategies that have been employed in the conduct of this thesis. Chapter Five introduces the data in terms of the themes that are systematically raised by research participants. This chapter raises some identified issues which impact on nurses in the specificity of place, as

opposed to all nurses. Chapter six deals with the issue of skilling as a contested terrain in more depth, since as is suggested in the literature review and the data, skill requirements in the town have shifted significantly towards a multiskilled environment. There are tensions associated with this phenomenon and controversy over who gets to define skill. Chapter seven deals with the issue of mobility. Mobility for work has traditionally been the prerogative of male workers. However, the issues associated with mobility for a woman's paid work are more diverse and include the tensions around the dynamics of 'breadwinning', commitment to paid work, disturbance to children and the likelihood of partners gaining work elsewhere. These issues are explored in the context of the new positioning of nurses in the town within the framework of health restructuring.

CHAPTER ONE

Space/Place and Health Restructuring

Health care restructuring can not be seen to be an overarching process that is experienced similarly in different geographical sites. In this chapter I am interested in exploring the spatial dimension of the impact of health restructuring *on place*. It is at the level of the locality that the notion of 'place' and how the dynamics of health restructuring are spatially bound is most evident. At this local level it is possible to make tangible the web of connections which crosscut capitalism, gender relations, and the individual in this era of global restructuring. My aim here is to explore the restructuring health services in the town as a site where, in Foucault's words, "discourses about power and knowledge are transformed into actual relations of power" (cited in Soja 1995: 28).

The introduction of the market model into health care has had differential effects on people and places. While people are all differentially located in space, McDowell (1996) argues that there are radical inequalities in the spatial spread of individuals' lives. Place matters; it materially influences the way in which people live, work and structure their daily lives, and this in turn has an impact upon that same place. This suggests that the 'impact' is not a one-way process and we can see that "social and spatial relations are dialectically inter-reactive, interdependent; that social relations of production are both space forming and space-contingent" (Soja 1989:81). Thus capital and space constitute key factors in the process of the restructuring of the workplace, and in particular, the health sector in which hospital downsizing and the desire for an increasingly flexible workforce are being manifested.

Health constitutes an integral part of the service sector which has undergone unprecedented growth in recent times. With the rise in importance of the service sector, Walby et al. note that health work has become more typical of contemporary forms of employment than the industrial models conventionally studied (1994:2). Restructuring in the service sector can be seen to be quite different in some ways to

restructuring in manufacturing since the work done in producing health care is hard to measure. Further, restructuring in the public sector is distinct again from that in the private sector since, as Lash and Urry note, there is, firstly, a lack of profit[10] as a motivating factor[11], and secondly, "there is an obligation on much of the public sector to provide roughly equal, or at least minimum, levels of provision, supplied to consumers roughly in the areas in which they live" (1994: 207), this second factor constrains one of the key ways in which restructuring works and that is by spatial relocation (ibid 1994).

Restructuring of the Health Sector

The timing of health sector restructuring was so definite that Ashton (a critic of the process of reform) felt able to state that "[i]n July 1993, the New Zealand public health system was radically restructured" (1999: 134). This restructuring, following the 'more market' policies in other arenas, introduced competition into health provision by splitting the funding body from those who provided the health services. The effect of this action was to promote competition between health care providers and thus, supposedly, increase 'efficiency'. Ashton notes that the stated objectives of the health reforms (quoting Upton, 1991, p.3) were the following:

- improve access for all New Zealanders to a health system that is effective, fair and affordable;
- encourage efficiency, flexibility and innovation in service delivery;
- reduce waiting times;
- enhance the working environment for health professionals;
- recognise the importance of the public health effort in preventing illness and injury and in promoting health;
- increase the sensitivity of the health system to the changing needs of the population. (Ashton. 1999: 135)

---

[10] Although 'profit' is not gained in the conventional sense in state sector restructuring, the motive of attempting to save the government money by rationalisation and restructuring carries the same sort of connotation as a profit incentive. Thanks to Dr Jaber for pointing this out.

[11] However there have been some attempts to introduce internal markets such as the initiative in Christchurch where two of the hospitals in the city were under the jurisdiction of different regional health authorities. Interestingly, this internal market is in the process of being abandoned now in mid 2000 having been in place since the early 1990s.

Further to the above strategies, the population-based funding formula, which had already been introduced in 1983 by the Ministry of Health had resulted in, broadly speaking, the reallocating of funds from the south to the north of New Zealand. According to Barnett and Barnett, population-based funding was an attempt to depoliticise the allocation process (1999: 225) by using the simple logic of differential population numbers. Adjustment to this allocation, however, was required for differential age of population and also distance from services. This adjustment is crucial in relation to funding, because older people tend to need more medical care, and increasing distance from services can result in inequity in terms of service access. It is interesting to note that the area involved in this study has 22.1 percent of the population over sixty years old as compared with a national average of 15.4 percent (Census Figures, Statistics New Zealand 1996).

Restructuring Health In Towns

On a regional level, attempts to implement the above objectives have resulted in the closure or downsizing of some hospitals. The area in question in this study has downsized since the 1980s to one multipurpose ward, a maternity area, a small high dependency unit and an accident and emergency department. In its previous larger form the hospital consisted of six wards, including two medical, two surgical, one geriatric, one mixed paediatric and acute ward[12], including coronary care, a maternity annexe, as well as accident and emergency, operating theatre and outpatient areas.

As has been previously noted, part of the downsizing strategy has been the withdrawal of surgical services from many towns hospitals. This withdrawal has resulted in the immediate loss of an ability to practice either theatre nursing, recovery nursing or surgical nursing[13] as specialty areas. There have been a series of flow-on effects from the lack of surgical services (see Fougere 1995: 18). Less acute trauma comes to the hospital since there is no surgeon to operate should that be required. Patients being

[12] An acute ward is one where more seriously ill patients are admitted for initial observation and stabilisation prior to acute surgery or medical intervention.

[13] There is still 'space' for non-acute postoperative care nursing as patients are transfered back from the city hospital after surgery.

observed for potentially surgical conditions tend to be sent to the city hospital earlier since, again, there is no surgeon to operate should this be required.

In terms of the nursing work that remains at the hospital there tends to be a broad range of less acute patients. However, this tendency is disrupted by the need to provide facilities for people with such things as myocardial infarctions (heart attacks), which are often very acute indeed and need immediate (therefore local) specialist care. Not all patients are able to be airlifted to base hospitals without stabilisation of their condition, therefore some acute and highly skilled work is required *in place*[14].

A further expectation of processes of restructuring was that hospitals in some towns would be taken over by local community trusts as regional health authorities withdrew from the provision of services in rural areas including some towns. According to Barnett and Barnett, although community trusts are a flexible model of service provision in that they can be responsive to local communities, they are, never-the-less, "demanding of local communities in the sense that they are 'do it yourself health care'" (1999: 227).

Hospital closures or downsizing are frequently justified with recourse to what Barnett suggests are "somewhat suspect arguments relating to travel time, population thresholds and intraregional equity of access issues" (1999: 7). These arguments are suspect in the sense that these 'justifications' do not help to explain that some hospitals remain well staffed and maintain bed numbers while others have experienced several rounds of restructuring and have lost bed numbers and surgical services in spite of, in some cases, being further away from large base hospitals. The political manoeuvring that may be taking place in this instance is not transparent, but clearly there is more at stake here than simply following the logic of instrumental rationality. Different locations can, it seems, marshal different resources and responses from governing bodies; thus socio-political location needs to be explored in

[14] It seems likely that lack of backup surgical services would also place a greater burden on ambulance staff, since they are the ones that must make a decision whether to call the helicopter (from the city) or take a patient to the local hospital.

order to begin to understand the context from which nurses in the town speak. Again, space/place matters.

Space/Place and the Dynamics of Power

To pay attention to space/place in this way is to respond to the call by geographers and others who have suggested that we need to, not just take location into account, but to engage in a process of questioning the privileged place held by time and history. Space, it seems, has occupied a peripheral rather than central position in relation to history (Soja 1989) and Foucault insists that "a whole history remains to be written of spaces - which would at the same time be a history of powers" (1986: 14).

The notion that place is seen as a fixed, apolitical, solid entity is problematised in the sociological literature and the rhetoric of spaces, including cartographies and flows, has been shown to be intimately linked to questions of power relations and politics. Indeed it is suggested that:

> We must be insistently aware of how space can be made to hide consequences from us, how relations of power and discipline are inscribed into the apparently innocent spatiality of social life, how human geographies become filled with politics and ideology.
> (Soja 1989, p.6)

There is a clear acknowledgment that space/place[15], both literal and metaphorical, does need to be understood as a crucial component of analysis of political investments and power relations. However in the mainstream literature there is a paucity of research on small towns, particularly in comparison to that body of literature dealing with the urban and the rural. Although, in general terms, the town appears to be under- explored, there are a few studies in New Zealand which do begin to deal with the concerns of the town and restructuring. Amongst these are the publications of Britton et al. (1992), Le Heron and Pawson (1996) and Conradson and Pawson (1997). The works by Britton et al. and Le Heron and Pawson provide a broad overview of processes of restructuring in New Zealand in the 1980s and 1990s. These also offer vignettes of a variety of towns in New Zealand and the responses they have made to the processes of restructuring. Conradson and Pawson's work

[15] I have used space and place interchangeably since they are implicated in the construction of each other.

begins to address the town as a case study, which provides very useful general analysis of the process of restructuring, but pays scant attention to the health sector and no attention to nurses. Kearns and Joseph (1997) specifically address the issues of health restructuring and rural communities in New Zealand as does the work of Barnett and Barnett (1999). However, the above works do not provide analyses of *nursing*, and so do not go far enough for my purposes. The town, in general terms, remains under-explored.

In some sense the town seems to occupy a middle ground both literally and metaphorically, the half-way place. Those who live in towns may be subjected to at least two gazes, depending on the specific location; for example, from the perspective of the farmer (the 'real' rural dweller) town dwellers may be called 'townies'[16]. The gaze from the perspective of the urban dweller is often also derisive and those who live in 'hick towns' may be perceived as lacking in sophistication and be seen to be 'country bumpkins'. Town dwellers are thus part of a relatively invisible group who seem to 'belong' to neither the city nor the farm, and in fact may be treated with some suspicion by both groups, as neither here nor there, if you like. However, town dwellers themselves have a clear sense of place, and indeed, in terms of the surrounding farming community, the town can be seen to be a centre. But, in a world governed predominantly by dualistic modes of thinking, the 'middle', the 'in-between' is not thought of, spoken or theorised easily.

A useful way to begin to think about this 'seeming to belong no-where' is to use Bhabha's notion of 'in-between' space. This seems to be evocative of the place of the town[17]. Articulating the emerging space of hybrid identities, Bhabha suggests that:

> these 'in-between' spaces provide the terrain for elaborating strategies of selfhood - singular or communal - that initiate new signs of identity, and innovative sites of collaboration, and the act of defining the idea of society itself. (1994: 1-2)

---

[16] This term is used by a number of my uncles to denote those who 'don't know' about farming, animals and crops. As far as I can make out it seems to be a term of derision.

[17] It is important to note that I do not wish to equate postcolonial issues (which are Bhabha's central concern) with space issues as they are presented in this thesis, but simply that Bhabha's notion of 'in-betweeness' seems appropriate here.

This notion of Bhabha's gives a sense of the town as a site of possibility, of re-definition, yet at the same time, the space 'in-between', can be seen as a site of invisibility or marginality. In terms of redefinition, the ways that power and knowledge are utilised can be crucial in the reconfiguring of health care, nurses' tasks and hence, nurses' professional identity.

So how can we begin to understand the marginality of the town, since towns at one time were very important and central places. According to Shields, this marginality is a feature of those:

> towns and regions which have been 'left behind' in the modern race for progress .... They have been placed on the periphery of cultural systems of space in which places are ranked relative to each other. (1991: 3)

This ranking, moreover, into centres and peripheries, obscures the dependence of the one upon the 'other', thus:

> The social 'Other' of the marginal and of low cultures is despised and reviled in the official discourse of dominant culture and central power while at the same time being constitutive of the imaginary and emotional repertoires of that dominant culture. (Shields 1991: 5)

Soja is instructive regarding the relationship of dependence between centres and peripheries by suggesting that:

> Under advanced capitalism the organisation of space becomes predominantly related to the reproduction of the dominant system of social relations. Simultaneously, the reproduction of the dominant social relations becomes the primary basis for the survival of capitalism itself. (Soja:1989: 91)

Thus, Soja proposes that the contemporary period, characterised by processes of restructuring nationally and internationally, is one in which capitalism seeks to secure the key conditions for its survival. One of the ways that this process is manifest is in the juxtaposition of under and over developed areas (Soja 1989). This juxtaposition, otherwise called geographically uneven development, is seen to be necessary to capitalism. It ensures a ready supply of labour which can move to fill gaps in the labour market elsewhere (Massey 1984). On a global level under and over development are not difficult to identify and a similar process would appear to be functioning at a national level, with regions within many countries becoming poorer,

depopulated[18] and losing services. Correspondingly, the urban and especially the larger urban areas have experienced growth and development, perhaps as it has been suggested, at the cost of this regional underdevelopment.

Though this is a very promising beginning to an understanding of the town as peripheral, it should be noted that Soja has been criticised by, among others, Massey because of his tendency (though acknowledging the need to take race and sex into account) to advance the notion that:

> [T]he only axis of power which matters in relation to these distinct forms of domination is that which stems fairly directly from the relations of production....The fact that patriarchy, for instance, is not reducible to the terms of a debate on modes of production, is not considered. Indeed, to take the point further, modernity itself is defined entirely in relation to capitalism, at times seeming almost equivalent to it. (Massey 1994: 222)

Clearly, then, it is important to broaden the discussion beyond only relations of production. One of the ways to move beyond an analysis of capitalist relations of production is to begin to look at the links between the global and the local. This approach is evident in, for example, McDowell and Massey's work and prompts attention to be paid to concepts such as 'global localism' or ("glocalization" as McDowell 1996 terms it) and "a geometry of multiple difference" which, as McDowell argues, "recognises the unevenness of the disruptive impact of interconnected global capitalism on particular localities, knowledges, and place-based identities" (cited in Duncan 1996: 6).

Restructuring Paid Workers

The focus on place-based identities is crucial since it moves beyond a perception of restructuring as a simple imposition of policy, a top-down economic imperative. In their effort to explore the position of gender in restructuring and in order to disrupt the dualistic notion of 'restructuring' and its 'impact', Halford et al. draw attention to the people that comprise organisations. They indicate that it is the occupational actor

[18] The area in question in this thesis has a projected population change between 1996 and 2021 of minus 18 percent. Though on one level this point could be used to justify gradual and continuing withdrawal of services, it is also possible to argue that is precisely because of the withdrawal of services that the population in some areas is projected to decline.

that is changed in the process of restructuring the health sector (or other service sectors for that matter), in arguing that:

> far from simply changing *structures*, which then impacts on employees, restructuring is tied up with redefining and contesting the sorts of personal *identities* and *qualities* which are seen as desirable or undesirable for organisational members to possess. People themselves are not simply passive recipients of such organisational changes and may be able to contest and reinterpret them. (Halford et al. 1997: 65. Emphasis in original)

This view contests the 'restructuring paradigm' in which "organisations tend to be characterised as rational instruments in the implementation of economically driven strategies for change" (ibid 1997: 64). The expansion of the notion of restructuring is consistent with Larner's conception of the market relations promoted within restructuring as governance. She argues that:

> market relations are relations of governance in that they are attempts both to constitute and fundamentally to transform the subject's capacity to act. As such, market governance involves new forms of political power premised on the mobilization of particular identities. (Larner 1997: 373)

Spatialised identities do not have a fixed, enduring meaning, but rather, exhibit shifting meaning over time. What 'nursing' *means* in the town is not the same now as it was ten years ago.

In order to further explore the often taken for granted, but very intricate ways in which women's professional identities are positioned in paid work, it is important to turn to firstly a more general picture of how work identities have been, and are constructed and contested before beginning to look at how nursing itself has developed. The positioning of nurses (who are mainly women) within paid work, in an occupation which is at once in the public sphere but carries markers of work done in the private sphere, is very complex indeed. An exploration of the way in which nursing has developed allows for a contextualisation of the identity which nurses bring to paid work.

CHAPTER TWO

Gender, Paid Work and Nursing

Over time there has been a raft of changes in the way the workforce is structured, but there are also some remarkably persistent patterns of expectations and behaviour in terms of women's marginalisation in the workforce. The first part of this chapter will explore the positioning of women in paid work in a more general sense, while the second part will deal with the context out of which nursing developed and nurses' current positioning in paid work, paying particular attention to the "conundrum of care" (Davies 1995) which is an enduring dilemma for nurses.

Traditional Constructions of 'Worker'

Since the time of the industrial revolution when people started to move out of the home to engage in market work it has come to be assumed that a 'worker' was male, and usually one with a support team at home preparing him daily for his sortie into the public world of work. The division of labour between the male public sphere and the female private sphere was seen to be 'functional' in that it took care of both spheres, although in a highly gendered way. Traditionally it has been assumed that a paid work, or professional identity was not important for women. Women's identity was provided by its association with the domestic sphere.

Although there is no explicit hierarchy attached to the public/domestic spheres and even though domestic work was seen to be 'functional' to the operation of the public, it was (and still is) not considered to be work in the same way that was carried out in the public sphere. The 'home work' that was often associated with caring and was unpaid was not simply seen as different and 'equal' but rather as a form of life activity which carried less status than men's paid work.

The rigid division between man as the paid worker and woman as the homemaker has been shown by many authors to be somewhat fictional and a feature of the lives of *some* women and men. Women have, of course, always 'worked' in one way or another in more or less satisfying ways; and, as more and more women have entered

paid work[19] the traditional construction of 'worker' has been challenged. Yet in spite of many years of this challenge women still predominantly inhabit the ranks of the lower paid, the part time and the casual. Arguments have been advanced by the human capital theorists that suggest that women predominantly occupy this positioning in the world of paid work because they have a primary orientation towards the child rearing role (Wajcman 1996: 261). Thus they do not invest in their own human capital by training and education and, further, employers do not believe that it is worthwhile to train women since they leave for childbearing/rearing reasons. Some women do, in fact, leave, or at least, take leave, from work for these specific reasons. However, women no longer tend to leave paid work permanently for domestic reasons.

Feminist Debates About Work

In the 1970s liberal feminists claimed that what women needed in order to be equal to men (who were the standard) and to have a visible place in the world was to fight to be included in the paid (public sphere) workforce. Many gains were made as a result of this struggle, including much legal reform which protects women to some degree from discrimination in the workplace. However, it has become clear that adding women into work as it is currently structured has not been the success that was expected. The world of work that women pushed to gain access to was not an egalitarian place in which merit was the arbiter. The embodiment of women continued to mean some of them/us wanted to have children. More and better childcare still did not necessarily mean that women could be at work 'as men'. Further, women still did, and continue to do, the bulk of the household work as well as engaging in paid work. The situation was rather more complex than was initially assumed.

The sole focus on market work, rather than a more inclusive view of human life, has been critically addressed in feminist literature. hooks, for example, notes that it is assumed by many middle class white women that work is a means of something

[19] A number of authors, Hakim among them, argue that there has in fact been no increase in the number of full time equivalent positions over time, but rather just more women doing part time work.

called liberation. However, the reality for most women of colour, as hooks points out, is that the paid work which many engage in is often of a type for which 'liberation' would involve *not* having to engage in it. Work, in this sense, is not an unmitigated good, not part of an identity definition which is treasured and wanted. It is more about self preservation than self-realisation (Barber quoted in hooks 1984: 97). This awareness presents a challenge to the imperative to paid work. The issues around paid work can be seen to extend further than either to have the right to participate or not, and the split between family and market work is never complete for women nor assumed by nurses.

When women do work it has often been assumed that they do so only for the money (either for extras or for fundamental family needs) and have none of their identity tied up in paid work, although this is gradually changing. The fact that women still tend to do the bulk of household work seems to have resulted in a slippage where an outcome is seen to be a cause. Becker (1976, 1981), for instance, "argues that married women's lower occupational attainment can be explained in terms of rational economic choices: since their wages are generally lower than their husbands' it is women whose employment is limited by domestic responsibilities" (cited in Arber and Ginn 1995: 23). Arber and Ginn also note that it can equally be argued that it is precisely because this "vicious circle" is created whereby women are positioned as predominantly responsible for domestic responsibilities, that we have constrained employment opportunities (1995: 23). A tangled web indeed.

Work Under Restructuring

At this time of restructuring in New Zealand the way in which work is perceived shows a subtle shift in thinking. From an assumption that women's work was dispensable, secondary and marginal, we are now to assume that in some sense market work, in this economic climate, appears to be "de-gendered" (Larner 1998c) which is possibly a liberal feminist aim. As Larner points out, "Governmental programmes and policies are involved in the process of subjectification and contain assumptions about desirable ways of being and behaving" (1998: 4). Thus, in an economic climate that has seen serious threats to the longstanding welfare state, it is

not surprising that the government would insist that an economic identity as a paid worker is "the key to social inclusion for both men and women" (Larner 1998: 2). Indeed, it was suggested in *Government Management: Brief to the Incoming Government 1987,* that market employment is "critical to the social identity of most people" (cited in Else 1992: 243). Further, since all people seem to *need* to participate in the market; one has to ask if we are witnessing the death of Pateman's (1988) "sexual contract". Yet McDowell is cautious in this regard. She argues that:

> current definitions of patriarchy, at least as applied to economic restructuring have proved an inadequate theorization of contemporary changes, disguising the ways in which new divisions in the labour market are opening up among and between women and men. (1991: 416)

Although the 1987 Government Briefing Paper also acknowledged the importance of unpaid 'family' or 'care' work, this position becomes difficult to sustain according to Else, who notes that:

> having children is seen as an irrational desire, because of the cost and dependency[20] of the caregiver and child to the family ... the interests of mother and children are seen as conflictual and competing, because the child's need for care are clearly in conflict with the mother's needs to compete in the market economy. (Else 1992: 244)

In New Zealand it would seem that at the base of this process of economic restructuring is the market worker, the rational economic actor; one who is apparently "unhindered by responsibilities for caring work" (Armstrong 1992: 228). Further, it is assumed to be the *mother* who will be in conflict with the child in her need to compete in the market economy. The public and the private are indeed in a conflictual relationship. This is an old, old story.

Separate Spheres?

Much feminist energy has been expended on the debates around the so-called separate spheres (the public and the private). So much, indeed Pateman comments that the "dichotomy between the private and the public is central to almost two centuries of feminist writing and political struggle; it is, ultimately, what the feminist movement is

[20] It could be argued that the caregiver is in fact not dependant at all since that person does the domestic work that assists the paid worker to do their job. The caregiver may be seen to be *financially* dependant but it is hard even to argue that this is the case.

about" (Pateman 1988: xxi). While this may be a little overstated it is never-the-less the case that analysis of 'the spheres' have been central to much feminist effort.

However, Kobayashi et al. note that several decades of feminist theorising has shown the separate spheres debate to be conceptually and theoretically limited for it simply explains too little and that more recent theorising has shown that the two spheres are seen to be interconnected and relational (1994: xxvi). The connected nature of the two spheres becomes very clear in this study in terms of the complex notion of a 'caring' 'job/profession' (which is in some ways a contradiction in terms), since 'care' is seen to belong to the private and 'job/profession' to belong to the public.

Kobayashi et al.(1994) identify the notion of patriarchy proposed by Walby, as being particularly useful to the analysis of gender relations. Walby suggests that as there has been an increased demand for women's labour, there has also been a transformation in the operations of patriarchal power. The shift that she identifies is from a predominantly private form of patriarchy to one which is predominantly public. In the private or "domestic form the principle patriarchal strategy is exclusionary, excluding women from the public arena; in the public it is segregationist and subordinating" (Walby 1997: 6). Again, Walby (1997) points out, that this is not to say that private patriarchy ceases to exist, but rather that it is situational; that is, related to age, location and many other factors. For example, older women who do not participate in the paid workforce are often more subject to private forms of patriarchy. Kobayashi et al. contend that this:

> analytical distinction provides a refined sense of those conditions under which patriarchy develops, and allows our emphasis to shift to the *sites* in which gender relations are played out rather than focusing, as was the case in earlier work, upon the roles appropriate or expected within particular spheres. With this new focus, *context* becomes of crucial importance. (Kobayashi et al. 1994: xxvi. Emphasis in original)

The health arena is a good example of a "site in which gender relations are played out", in that the largest occupational groups are segregated by gender (although this situation is changing more rapidly in the case of doctors). Furthermore nurses, as was

argued in the introduction, are marginalised and subordinated in comparison to doctors.

Nursing in Context

In order to contextualise nursing, it is important to highlight the ways in which nursing has developed and changed. To this end, changes in nursing education, the professionalisation debates and the conundrum of care are introduced in the following sections.

Changes in nursing education

Nurses, in the past, were trained in hospitals in both large and smaller centers of population. The trainee (usually a woman) went to live in a 'nurses home' or hostel and worked at the adjoining hospital on a full-time, rostered shift-work basis. The training consisted of either regular study days (approximately one per week), or block courses of theoretical and practical instruction interspersed with practical work. After three and a half years of this training, state examinations were taken and if passed the nurse became a 'Registered Nurse'.

The hospital-based system of training provided instruction for many women at a time when teaching, secretarial work or nursing were the only three jobs that many girls were aware that they could pursue. In rural areas and small towns young women had to leave the area in order to go to Teacher Training College, while nursing training was available at the local hospital. This proximity was an important means of gaining a credential that many women would otherwise not have had access to. An advantage of hospital-based nursing training was that it came with accommodation and a wage. This opportunity was very important to many young women (the army is probably the only place left where accommodation and a wage are provided while training is carried out). The hospital-based system of training provided a world recognised qualification in an accessible way for people in non-urban locations.

There was a clear expectation (which was fading in the late 1960s) that nurses would leave nursing once they married and indeed many of the women I interviewed relayed

stories of remarkable incidents which reflect the challenge that they made to this expectation. The timing of these challenges to established protocols coincides with an era of global social ferment in which the position of women, people of colour and minority groups as inferior or second class was questioned. Many women at this time became much more aware of how they wanted to position themselves in their worlds and took advantage of opportunities that began to open up. An example of this growing awareness is evident in an article written by a student nurse in *The New Zealand Nursing Journal: Kai Tiaki* in 1972. She writes that nurses were unhappy with their status and that they:

> are no longer willing to be regarded merely as the hand maiden of the physician. It means that their professional association has developed a sense of autonomy, prepared to take its own informed stand on issues affecting public health. Resulting from this dissatisfaction is a high withdrawal rate from the profession and hence the existing shortage of nurses. (Miller 1972: 26)

While it is unlikely that dissatisfaction with the status accorded to nursing was the sole reason that there was a shortage of nurses at the time Miller wrote this piece, it never-the-less shows a clear shift in thinking about the position of the nurse within the health system.

In the last twenty years nursing education has undergone some rather fundamental and dramatic shifts, all of which aimed towards increasing credentialism. The above apprenticeship system passed out of favour in the early to mid 1970s and was replaced with training in Polytechnics. The Polytechnic course consisted of a much greater theoretical component, a smaller practical component and the trainee was not attached to any particular hospital. The emphasis in the above shift has been on "breaking the link between education and service" (Davies 1992: 236). These nurses, when they graduated, became 'Comprehensive' nurses. Nurses are still trained in Polytechnics, which, in the main, are located in larger centres, but their course is now a degree-based program, with nurses graduating with Bachelor of Nursing degrees at the completion of their study. So over the space of twenty or so years nursing has shifted from being an apprenticeship to being a degree program, based on credentials rather than competence alone. This shift has not occurred without its critics, and

indeed was hotly debated through its every step; Smith, for instance, a registered nurse writing to *The New Zealand Nursing Journal: Kai Tiaki* insists that:

> Above all our profession must guard against an education that produces the academic nurse graduate who, isolated from involvement in the practical situation can never fulfil her role as a nurse. The nurse we need is one who can practically relate her knowledge to the care of her patient with understanding, tolerance and compassion. (1972: 7)

Credentialism has been the route that nursing has followed in order to assert claims to the status of a profession.

Professionalisation debates

The professionalisation debates in nursing are on going and range from those who think that nursing should professionalise to those who think that it is already a profession. There are also some who argue that nursing is a 'lower order' profession (Abbott and Wallace 1990). Still others ask why nursing should want to be a profession given the masculinity of the professional model. The professionalisation project is further complicated by both the nature of nursing work and the way that nursing as a profession sits within the structure of health services more broadly.

If the general features that characterise a profession are taken into account, then nursing seems to have an incomplete fit with the (arguably masculine) professional model. For instance as Walby et al. state:

> The control over their [nurses] work by others, especially doctors, the rule-bound internal hierarchy, and the lack of control over the client who 'belongs' to the consultant are three of the features which preclude this [status of a fully developed profession]. (1994: 137)

One of the key ways that the move to professionalise has functioned is to make claims to a specific body of knowledge and skills that 'belong' to the nursing profession. This claim to expertise and autonomy is interesting in that it tends to construct the profession and its body of knowledge as conflicting with the state and its apparatus of control. Some of the governmentality literature, following Foucault, seeks to disrupt this dualistic formulation. Johnson, for instance, suggests that as expertise becomes institutionalised in its professional form it becomes part of the process of governing

(1995: 9). However since nursing has been argued to be a semi-profession rather than a full profession it is hard to say if these arguments can apply to nursing in the same way as they may be seen to apply to medicine[21]. Abbott and Wallace note that nurses have had trouble identifying "an autonomous knowledge base, to underpin an area of work where they are perceived as experts" (1990: 24). However, Thornley following Clay, argues that the professional model "usually draws on the more technical field of acute care to argue that nursing requires 'a certain level of intelligence, skill and knowledge' and can no longer be compared to nursing of the past" (1996: 173).

Basic nursing work is hard, heavy and dirty, which does not really fit with the notion of 'profession' with its focus on technical skill and expertise (Mackay 1990). Many, if not most, hospitals now practice a version of patient care in which a nurse is held responsible for everything about a particular patient (Primary Nursing), including both the hard, heavy and dirty work and the more technical aspects. Some of the core work of nursing such as 'body care' can be, at least theoretically, done by lesser trained staff. Nurses themselves defend the work that can technically be carried out by untrained staff by saying that they practise many skills while carrying out simple procedures such as taking a temperature or showering a patient. It is here, they note, that many observations may be made which would be missed by an untrained eye (incidentally, this is very hard to quantify). Registered Nurses would still, as a rule, take more complex patients as part of their patient load than would Polytechnic students in training or Enrolled Nurses[22]. The issue of patient complexity is important here since there are groups of patients for whom very little in the way of technical care is needed.

The use of the technical field of acute care as a type of benchmark for skill is of particular relevance in this study since much of the nursing work in the town is not highly technical or acute. If 'acute' and 'technical' are the skilled part of nursing then there may be a tendency for the less technical and acute areas of nursing work to

[21] The issue of how nursing may fit within the governmentality thesis could be a valuable exploration on its own.

[22] Enrolled Nurses completed a shorter training programme than Registered Nurses and are no longer trained. There are still a number of Enrolled Nurses in practice, and it has been proposed in 2000 that Enrolled Nursing be reintroduced.

become peripheral and de-valued. The above issues are further explored in the context of the data in chapter six where the issues of skilling and how it is constructed and contested in the town setting are highlighted.

The conundrum of care.

This somewhat confusing picture of an occupational group that has aspirations to professionalism while at the same time being devalued may be in part due to the nature of nursing work and its association with the notion of 'care' which is devalued in the community as a whole. So, for Reverby, in order to "explore the meaning of caring for nursing, it is necessary to unravel the terms of the relationship between nursing and womanhood" (1990: 133; see also Jolley and Brykcznska 1993, among others).

In the past nursing has given a sense of having been some kind of 'calling' or vocation. Florence Nightingale was primarily responsible for the beginnings of a change in what 'nurse' meant from the 'Sarah Gamp' figure of Dickens towards a respectable middle class woman (Godden 1997). Godden suggests that this shift was problematic in that earning money decreased a woman's status in the mid to late 1800s and in order to recover status to some degree, Nightingale's "trump card...was linking nursing to altruism - to the high status of philanthropic ladies such as Nightingale herself, and to the religious vocation of the nursing nuns" (Godden 1997: 184). Further to this, Nightingale instituted, within nursing, a class-based hierarchy of 'Sisters' (middle class) and 'Nurses' (working class). 'Sisters' 'supervised and guided' 'Nurses' (ibid 1997: 185). A clear notion of nursing as vocation comes through in the writings of Elizabeth Glover, a high profile nurse in Australia in the early 1900s, who notes:

> A nurse's life is hard and full of self-sacrifice.... We must not measure our hours of labour, but rather regret that we cannot do more .... A good nurse can never be compensated by money. She must be paid ... but her work must be something better, something higher, and I may add purer and holier than the ordinary commerce of today. (Glover cited in Godden 1997:181)

It will be no surprise to learn that Glover opposed the eight hour day in Australia as something appropriate to 'trade' but not to nurses who "were professional women

who would work for the benefit of mankind all day if necessary" (Godden 1997: 180). This notion of nursing as a vocation could be argued to be somewhat out dated, yet it is this complex legacy that contemporary nurses call their history.

'Vocation' "epitomised the belief that nurses brought not only natural skills to their chosen occupation, but also deeper qualities of giving and lack of interest in financial reward" (Smith 1992:30)[23]. Davies suggests that much of this type of thinking has rested upon idealising care by women in the home, which has guaranteed its underanalysis. She suggests that if we pay attention to some of the negative aspects of caregiving in the home this may help to release us to consider forms of paid caregiving in a new light. "Paid caregiving can thus be seen not as a poor and somehow always unauthentic substitute for 'real care', but as an activity that has the potential to overcome some of the tensions and dilemmas of home-based caregiving" (1995: 142). Note that Davies uses the word 'potential', this particular 'potential' is as yet unrealised.

Care is a word which has a long and tortuous history in both the feminist and nursing literature in which the so-called "care debates" have raged and continue to do so. There seems to be a continued tension between the essentialising tendencies of those who would promote a notion of re-valuing care and its association with women, and the professionalisation debates (with their focus on skill and expertise) that seem to place care in a peripheral position. Waerness, in this instance provides an explanation as to why care may be pushed to the periphery in professionalisation projects. She notes that:

> because the head-heart duality is accepted in all sciences, it seems probable that any kind of formal education based on scientific knowledge will to some degree promote a more instrumental attitude towards work, at the expense of the expressive. (1992: 223)

However Davies challenges this solely dichotomous construction by insisting that nurses "frequently face the issues of reconciling professionalism and caring as

[23] This sense of nursing being a vocation is challenged by the answer to my question in this study; Have you always wanted to be a nurse? All but two of the interviewees said that they had originally wanted to do something else but had gone into nursing for a variety of practical reasons.

dilemmas of daily practice" (Davies 1995: 145). Davies seems to be indicating here that 'care' does not disappear as a result of the professionalisation of nursing. However, all of this discussion depends upon the interpretation of the word care.

Care for nurses seems to encompass both the skilled tasks required in order to administer drugs and treatments plus the physical tasks which include body care (toileting, teeth cleaning, cleaning up soiled beds and so on), as well as the emotional labour (Hochschild 1983) which is also a major component of nursing. These things are not separate but very much intertwined in the provision of full care for a patient. Care in a more commonsense, or perhaps domestic, understanding may not encompass so many of the factors that care includes in nursing and perhaps most importantly 'care' is hard to measure.

In the contemporary health care system with its focus on efficiency and accountability from health care staff, there is usually an effort to measure and quantify what occupational groups 'do' at work. Care work is, as has been noted, hard to measure and quantify and hence can become invisible when the instrument used to measure it is so blunt, thus:

> [a] responsibility accounting system [such as resource management] develops standards of behaviour such that 'normal' practice cannot only be defined, but also measured, and deviations noted. What is also implied is that what is rendered visible, measured, and rewarded gains legitimacy. Conversely, that which is not recognised by the formal system is often neither rewarded nor legitimate.... (Bloomfield et al. 1992; cited in Latimer 1995: 216-217)

The paradoxical nature of nursing work is highlighted in Smith's discussion of care. "Concepts of care" according to Smith:

> are fraught with contrasts and contradictions. Is it labour or is it love? Is it natural or is it a skill? Is it about feelings or tasks? Does it come from the heart, the head or the hand? Is it guided by mind or body? Or should caring be seen as an integrated whole? (Smith 1992:10)

The emphasis in nursing on the holistic care of the patient would seem to attempt to cover both of Smith's poles. Similarly Davies suggests that the care work that nurses do crosses the boundary "between the rational action that is appropriate for the public domain and the intimacy which our gendered thinking reserves for the private and

domestic one" (1995: 146). However, the rise of the concept of 'holism' in nursing dates back to the 1950s and '60s when the spiritual and psychosocial dimensions were identified as desirable additions to a purely biomedical approach to patients. Boschma suggests that this "holistic patient-centred approach can be seen as a professionalizing strategy with which to distinguish nursing from medicine" (1997:170). Holism was a direct challenge to what was seen as the reductionist tendency of medicine. However Boschma goes on to say that the focus on the psychosocial served to provide holism with a gender bias;

> The paradoxical nature of holistic patient-centred care concepts was that their description still resonated with the older idea of nursing as a higher female calling... when it was the nurse's female characteristics in particular that made her fitted for the job. (1997:172)

Thus the positioning of nursing here makes it sound remarkably similar to the positioning of the town in space; in-between or is it rather a bridge or a boundary crossing? It is this conceptual complexity with which both nursing and nurses grapple, whether consciously or not, in the construction of a professional identity.

To add to an already very complex professional identity which somehow holds, what can seem to be disparate concepts (care and profession) together, a further set of conditions are created in health sector restructuring in towns. These conditions can potentially weaken nurses' hold on what has been a hard won professional identity. The conditions which have been introduced are explored in the following chapter.

CHAPTER THREE

Management, Flexibility and the Reconstruction of Professional Identity

The restructuring of the health sector has included the introduction of new forms of management discourse. Essentially it is managers who implement the policies of restructuring and so it is important that attention is paid to how management might have changed. This chapter looks at changes in forms of management, before moving on the explore the implementation of flexibility strategies as part of the rhetoric of efficiency. Mobility, as a flexibility strategy considered by nurses is addressed and the issues of tension between home and paid work, including commitment to work are debated.

New Wave Management.

Along with the rise of the service sector and restructuring has come a change in the public sector which, as Exworthy and Halford note, has been "intimately tied together with critiques of professionalism and the emergence of a new form of managerialism" (Exworthy and Halford 1999: 7). This restructuring period has witnessed the rise of the generic manager and along with this has come a challenge to the position of professionals within organisations. In the past many people 'worked their way up' in a given organisation, for instance, in nursing many nurses worked their way out of clinical nursing and into management. Interestingly, however, having nurses in management positions does not always guarantee policies which are seen to be balanced between managerial and professional priorities. As one of the women I interviewed pointed out to me:

> *There are nurses in management who were once nurses, and there are nurses who are managers.* (Laura)

Now many managers are not trained within an organisation but rather are trained to 'manage' any area. The utilisation of generic managers seems to have been an attempt to avoid the conflicts of interest which may arise between professional and institutional allegiance when managers are also health care professionals. Thus,

Traynor, following Harrison and Pollitt (1994) points out that while older forms of management:

> saw their role as one of *facilitating* the work of doctors and nurses, not controlling or directing them.... the contemporary ethos is much more one of the professional as a member of a team, and beyond that, of an employing organisation. The presumption is that the individual professional will be subject to the rules, plans and priorities of that organisation....(1999: 10)

In the new positioning of the health professional within the restructured organisation professional principles need to be negotiated within the context of the priorities of the employing organisation. These conditions are added to by four restructuring strategies identified by Lash and Urry (1994) as centrally important; these are, intensification, commodification, concentration and domestication. It is intensification which is my central concern here. Lash and Urry note that:

> Intensification will result from the 'managers' in the organization being given clearer and specific objectives and being expected to meet them by managing their unit, and especially professional workers, more intensively. (1994: 209)

Nursing, however as Walby et al. argue, may be anomalous in new wave management terms, since it does not share all the characteristics of a fully developed profession (1994: 137)[24]. The key here, is the presumed lack of autonomy of nurses and the rule-bound nature of nursing practice. However, Walby (1994) also acknowledges that changes toward the practice of primary nursing[25] which has increased nurses' autonomy, may have already aligned nursing more closely with management expectations. Curiously, while managers are encouraged to manage professionals "intensively", professionals under new wave management are also required to be autonomous.

It can also be argued that changes in the definition of what it means to be a nurse are not confined to those mobilised by management strategies. Within the nursing profession itself, increasing credentialism, and more recently, changes in nursing

---

[24] The ambiguous positioning of nursing in relation to management evokes Bhabha's (1994) notion of the space in-between.

[25] The term 'Primary Nursing' refers to a shift away from the older task based model of nursing care in which many nurses were responsible, according to seniority, for a hierarchy of different tasks that needed to be carried out for each patient towards what is termed a more holistic model in which one nurse carries out all of the care needs of a group of patients.

registration place even more emphasis on nurses being responsible for their own practice. Changes in nursing registration include preparation for the introduction of Competence Based Practicing Certificates, where the nurse will have to demonstrate 'competence' by means of the presentation of a portfolio, in order to be issued with a practicing certificate[26]. These shifts alongside the strategies enacted by management together influence and may re-define what it means to be a nurse under restructuring in a town.

Organisational priorities within the restructuring health sector place a major emphasis on the quest for 'efficiency' in order to gain the most output for the least input. Efficiency can almost become an end in itself rather than being merely a tool, thus it "takes on a more general value and becomes a universal maxim for all intelligent conduct" (Winner 1977: 299, cited in Traynor 1999: 18). One of the ways that efficiency is made manifest is in the management strategy of flexibility

Workforce Flexibility

The intensive management of professional workers (nurses) in this restructured environment is made tangible in the notion of flexibility with its connotation of expansion and contraction according to need. Walby (1997) for example, notes two types of flexibility: "numerical" and "functional". The practice of flexibility appears to play a larger part in smaller hospitals, particularly functional flexibility. Dastmalachian, for instance, found that "hospital size relates negatively to numerical and functional flexibility strategies. That is, it appears that larger hospitals make less use of the flexibility strategies" (1991: 339). However, in New Zealand under restructuring it seems that numerical flexibility strategies are quite widely employed in hospitals of all sizes.

Numerical Flexibility

In numerical terms, flexibility is not a notion which is alien to nurses and nursing. Nurses themselves have demanded more flexible working arrangements. Registered

[26] It goes without saying that a nurse may not practice in the capacity of a Registered Nurse if s/he does not hold a current practicing certificate.

nurses, traditionally, were unmarried women who worked full time, and predominantly engaged in rostered shift work. It was assumed that if a nurse married then she would leave work which effectively constituted a marriage bar. Certainly some of the women interviewed for this thesis indicated that it was assumed that they would cease their nursing training once they were married or, most particularly, if they became pregnant. This norm had ceased to operate by the time I was training as a general nurse in the late 1970s. Although now nurses who continued working after having children needed to negotiate domestic responsibilities as well as paid work ones.

The challenge by nurses to previously inflexible working arrangements came in the form of pressure to engage in part-time work. Gradually, part time work became more acceptable, in spite of concerns on the part of management (which consisted of senior nurses at that time) that continuity of patient care would be disrupted if nurses were not predominantly full time. This reluctance on the part of management in the sixties and seventies would seem to indicate that, at least, the first moves toward more flexible working patterns were not predominantly management driven as much as requested by nurses themselves. However, a further condition may have contributed to the acceptance of part-time nurses by management. It seems that there may have been a shortage of nurses at that time which would make it prudent for management to encourage already trained staff back to work. Indeed a registered nurse wrote an article entitled "Problems of a Return" in *The New Zealand Nursing Journal: Kai Tiaki* in 1972 which indicated that:

> The present shortage of nurses has resulted in pressure being applied for trained staff to return to the profession....If a woman returns to nursing and finds that she is inadequate, or that the home arrangements are not working well, she should terminate the agreement as quickly as possible. She will find it too much of a strain to reconcile the two parts of her life, and her work (and therefore her patients) will suffer, and she will not be helping the nursing profession.
>
> But - and this is the important thing - if she does go back into nursing, she may well find that she enjoys it even more than when she was first trained; she will be doing fine community work; she will be a better person within the framework of her home because of her broader outlook and wider interests, and will be a more highly respected individual within her social circle. (Crews, 1972: 21)

I have included this lengthy quotation because it contains a number of themes that are dealt with during the course of this thesis: firstly, altruism, where "fine community work", not pay, is seen to be a motivation to return to nursing; secondly, the difficulty in reconciling the so-called two spheres, both public and domestic; and thirdly, the greater value placed on paid work with a focus on the professional ethic (this nurse assumed in 1972 that nursing was a profession while others were debating that status). It seems that some of the same sorts of issues remain problematic for nurses today, as will be further explored in relation to the data. Yet the ability to work part-time has been crucial to nurses.

Part-time work enabled nurses to maintain a paid work identity which had not previously been possible after childbirth. Full-time rostered shift work is hard to organise care for children around , bearing in mind the shifts that nurses work, unless the nurses has a stay-at-home partner. Also the demands of full time shift work are not to be down played, they are well documented elsewhere and need no elaboration here (see Preston et al. 2000; Monk and Folkard 1992; White and Bruce 1990; Simon 1990).

Management at this point in time does not only tolerate, but practices minimum core staffing. The strategy of minimum core staffing is a means of keeping nursing staff costs as low as possible. Intensification of the use of part time and casual staff, and also of late, limited term contracts[27] are the method used to cover staffing needs. So, it was not the case that management had to introduce part time and casual work to an organisation which previously had not practiced these forms of flexibility. Nurses in this sense had sown the seeds of what modern forms of management could build on quite easily.

In some ways this co-opting of numerical flexibility by management could be perceived to be a win-win situation in so far as nurses wanted part time work and are still able to do that. Yet the power balance can be seen to have shifted to management

[27] Limited term contract usually function over the winter months in large city hospitals when significant increases in admissions are expected.

taking control of flexibility strategies, while initially nurses themselves defined the terms of flexibility that suited their conditions of work. This practice is not confined to towns but is widely practiced in most hospitals at present. However, in the town in particular, this change in focus means that staff have on occasion been called back from annual leave to provide nursing cover and also that staff are not infrequently concerned about the skill mix[28] which they encounter at work.

Numerical flexibility contains, as has been demonstrated, a very important set of conditions, however, it is flexibility in its "functional" guise which is so crucial to the argument in this thesis. The quest for efficiency within the rhetoric of restructuring has meant that functionally flexible ways of working have been promoted in town hospitals.

Functional Flexibility

The expectation of functional flexibility, which effectively takes the form of multiskilling, is evident in several ways in smaller hospitals. Firstly, nurses in restructured and downsized environments often take on parts of some roles which have been carried out by other professional groups, for instance pharmacists. Secondly, nurses are encouraged or expected to take on a wider range of tasks within nursing, for instance they might be required to work both in a general ward and in an accident and emergency department. Within the general ward they are required to take care of a wide range of patients. Thus the boundaries around specialised areas in nursing in towns have broken down to some extent.

The breaking down of specialist boundaries in small town hospitals has not, as far as I am aware, been seen to be an instance of multiskilling or functional flexibility. Multiskilling is often spoken of (when it is spoken of at all) as a more gross measure with, for instance, the expectation that rural areas should be staffed by nurses who are

[28] Some nurses, even though they are registered nurses, may bring different levels of skill to their jobs. Of particular concern, for instance, would be staff who have been out of the nursing workforce for some time and those who are not involved in ongoing education. The introduction of Competence Based Practicing Certificates seems to me to be an attempt at "quality control" and thus at least theoretically should even out some of these differences. But whether the facilities will be available for town nurses to identify, maintain or reach competence level is a question to be explored.

also midwives to enable both areas (midwifery and general nursing) to be covered by one staff member[29]. It seems as if, in management terms, a nurse is a nurse is a nurse; they are all interchangeable and able to carry out anything designated as 'nursing' by management.

The hospital in question in this study has undergone a number of layers of change and downsizing and this has meant that the actual hospital building (the physical space) is always struggling to meet changing needs. Some of the tension involved in meeting the needs of a diverse range of patients in one ward may be intensified since the hospital was not initially designed to accommodate this. In some towns one response to this awkward situation is to purpose-build a hospital for its new role. Even with a better designed environment, nurses still have to attempt to meet the needs of a diverse range of patients in one area, however well designed.

Functional flexibility can be seen to disturb a sense of professional identity in that redefinition of nurses' work roles are closely related to perceptions of skill and the contest over the meaning given to skill by management and nurses. It is important to note that skill is not an objectively quantifiable entity but rather, "[i]t is a product of history: our institutions, the power of unions and employers, the technology of production, and the relative power of women and men" (Pocock 1988: 14). However, skill is not a notion which is so free floating as to resist any definition and nurses have a sense of what their skills entail and what constitutes a role boundary crossing. The impact of this newly defined role of nurses has contributed to a reassessment of professional identity by many nurses and this issue is further explored in relation to the data in chapter six.

The Occupational Actor

In some ways the discussion so far may begin to sound like a top-down imperative to change; however, in more recent literature there have been serious challenges to this rather simplistic model. It is argued that co-existent with the process of economic

[29] Some nurses have spent most of their working lives in multiskilled ways, however, most nurses engage in specialist work.

restructuring has been a shift in occupational actors which cannot be wholly attributed to the requirements of the market model. The picture is rather more broad than just a market that requires flexible labour, autonomous or multiskilled workers. This shift in thinking has attempted to "find a way beyond the dualistic accounts which routinely separate out 'demand' from 'supply' factors, or 'restructuring' from its 'impact'" (Halford and Savage 1995: 98). This more complex and nuanced approach was prompted in response to calls from anthropologists to place economic rationality in its cultural context (ibid: 99).

Apart from organisational culture which can influence the uptake and course of global and local calls to restructuring, the identity of the market worker also plays a part in the way in which any change in work is perceived. Although the notion of multiskilling or functional flexibility is somewhat slippery, some commentators, for example Piore and Sabel (1984) see multiskilling as representing an opportunity for "job enrichment and the possibility of a simultaneous increase in both worker satisfaction and productivity (cited in Walby 1997: 75). Others, as Exworthy and Halford explain, " see innovations and reforms as representing a threat to their sense of identity, and so will resist or adapt in order to try and maintain their old sense of self" (1999: 111). How change is perceived can be seen to be dependent upon many factors. Gender, position at work, importance of work for the individual, class, race, marital status, presence and ages of children and, significantly, geographic location may all be implicated in how change, be it multiskilling or other change, is experienced and negotiated.

Within nursing in New Zealand this notion that restructuring has not been "passively 'experienced'" (Halford and Savage 1995: 102), is given flesh by the contestation, protests, and proposals that have come from nurses over this time. This is particularly evident in the *New Zealand Nursing Journal: Kai Tiaki*, in which during the period of restructuring and increasing credentialism within nursing itself, the debates clearly attest to the importance of restructuring on peoples' lives. There has been a good deal of space devoted to the politics of health care delivery and also the shifting expectations of and by nurses, both around issues of credentialism and restructuring.

Nurses may resist what they perceive to be a unilateral redefinition of their professional identity by management strategies. As Walby suggests, there is a particular problem identified if "functional flexibility is introduced in an era of cost-cutting or cost-containment and workers refuse to implement new functionally flexible forms of working arrangements as part of a resistance to cuts" (Walby 1997: 75). Some resistance to working in multiskilled ways is noted in chapter six, however, another way in which resistance may be actioned, and flexibility can be re-deployed by nurses, is the possibility of mobility.

Mobility as Flexibility

Another form of flexibility which needs to be introduced here is that of mobility. Mobility can be seen to be "an important part of the government's aims - to ensure that people in declining industries had the motivation and incentive to move to where the work is, both in terms of geographical location and industry" (Callaghan 1997: xiii). Although Callaghan is speaking here of the British government, the concept of mobility is equally applicable to the New Zealand situation. The notion here is that labour will ideally be flexible, that is, flexible enough to relocate to where the work is.

Nursing in small towns can in some sense be seen to be a "declining industry", yet it is not in government interests or local management interests to have nurses relocate away from the town. The town situation is complex in that not only is there not a large number of nursing jobs in the locality, but, crucially, there is a relatively small number of nurses. However, as a result of changing conditions of work under restructuring, including losses in the area of pay and conditions, as well as the effects of both numerical and functional flexibility strategies, nurses may consider outward mobility from the town in order to gain access to larger employment bases. Yet the issues around women's relocating for paid work are very complex and it is here that the other factors which vie for attention in nurses' lives need to be explored.

Tensions Between Conflicting Selves: Home and Workplace

The negotiation of home and paid work identities need not necessarily be always and inevitably a problem but there are elements of this potentially 'split' situation which lend themselves to becoming problematic. While not all nurses work part time, most of those with children either do work part time or have at some stage in their careers worked part time. It has been suggested that it is the lack of adequate child and elder care that makes women work part time[30]. In addition women often still do a lot of the other invisible work, such as shopping (particularly for food), cooking, cleaning, administering family budgets and emotional work with children, partners and friends.

The thought that women would be free to participate in paid work 'as men' if there was just enough organised child, and perhaps also care of elderly people, is too limited a view. Women often carry a responsibility for far more than pure mechanical childcare or care of the elderly. This somewhat mechanistic view only serves to maintain the invisibility of all of the other unpaid things that many women do, and it also serves to highlight the dependence of the spheres upon each other with the public sphere still depending on unpaid work in the home. As Badgett and Folbre note, "dependants have been almost entirely omitted from mainstream economic (and political) theory" (1999: 315), this has also been highlighted by Waring (1988). Dependants usually constitute those who are children, the sick, or the elderly. Seron and Ferris illustrate this point further:

> because many tasks of the private sphere are associated with children and require some degree of affective concern, it is rarely possible to routinize and delegate all of these tasks to a surrogate. Rather, surrogates may help and even supervise, but some form of a more personalized arrangement for oversight is generally preferred. (1995: 26)

One way that women have restricted the potential demands for caring labour is by not having children, or leaving childbearing until much later in the so-called childbearing

[30] It is also interesting to note that Dex et al. (1993) found in a comparative study between British and French mothers, that French mothers who engaged in paid work, usually worked full time, while British mothers usually worked part time (at least while children were younger). At that time in France publicly funded care or schooling was available from the age of three years and prior to three there was extensive provision of subsidised care for children. It was not clear from this publication whether French mothers did less of the other care work that women often do or if they just worked extraordinarily long days.

years. Although not all women have children, many, if not most, women[31] will at some time in their lives be involved in the care of an elderly or sick friend or relative. Many women work part time in order to meet the demands placed on us, and which we implicitly accept, for all kinds of care, many of which are invisible to national accounting. However it is important to state that:

> Women make choices, but not in conditions of their own making. Women choose the best option that they can see, rationally, though usually with imperfect knowledge, but only from the range of options open to them. The decision as to whether to spend more time on the home or more time on paid work is a rational choice. But those choices cannot be understood outside of an understanding of the development of the institutions and structures which construct those options. (Walby 1997: 25)

Life is a very complex mixture of the pursuit of self interest and altruism and as such does not reduce readily to single causes and, in Badgett and Folbre's terms; "[i]n the larger process of cultural bargaining, women may prefer a world in which they continue to provide a disproportionate share of care to a world in which no one provides any care at all" (1999: 317). Further, for nurses, the issue of 'care' carries a double weight in that not only are many nurses engaged in unpaid care work in the domestic, but they are also engaged in paid care work in the public domain.

Commitment to Paid Work

The assumption of responsibility for 'care', as we have seen, often means that nurses work part-time[32]. Part time employment has often been looked upon with suspicion as a form of work which is not really 'committed' or serious. The centrality of a particular identity is often judged by the degree of commitment which the person shows towards engaging in activities that enhance that identity. As Bielby and Bielby note, in their extensive work on commitment to family and work:

> commitment is seen as an attachment that is initiated and sustained by the extent to which an individual's identification with a role, behaviour, value, or institution is considered to be central among alternatives as a source of identity....[C]entrality of identity implies that it is particularly significant, meaningful, or salient within an individual's personal hierarchy of identities or self-meanings. (1992: 284)

---

[31] This is not to say that men are never responsible for these types of care, but merely that women much more often assume responsibility for them.

[32] Not all nurses work part-time in order to privide care. Some engage in several jobs, of which nursing is one, thus, a part-time one.

Thus part-time work can be seen to be another way in which workers are marginalised. However the situation is not so clear cut and simple. Walby (1997), for example, notes that part time working is one of the ways in which flexibility is gendered. In this sense those engaged in this work are sometimes argued to be secondary earners with a lower attachment to work than those who work full time, even though there is an increasing trend for more and more people of both genders to be part-time or casual workers.

An issue which must inevitably arise here is that if the 'worker' is still thought to be full time and unencumbered, then what impact does this seeming 'choice' to participate or prefer part time work have on the (often female) worker? While at first glance, those that work part time may be argued (as Hakim did in 1995) to be less committed to their work, this may not necessarily be the case. Davidson and Bray note that:

> Increasing demand for participation in paid work by women, in the absence of any fundamental change in the household division of labour, has contributed to the expansion of the number of women in part time work. This part time work is for many women a workable compromise between the conflicting demands of home and workplace. (1994: 15)

There is much debate in the literature regarding the correlation between part time work and commitment to work. Some argue, for instance Hakim (1995; 1997) that those who work less than full-time show a lower work commitment, since part timers are 'choosing' to limit their participation in paid work. But Ginn et al. point out that the number of hours worked cannot necessarily be equated with depth of commitment. They claim that "it is possible to be highly conscious of the needs of one's family and at the same time to care deeply about maintaining employment" (1996: 168). Some full time workers are financially committed to work but have tenuous attachment apart from the financial factor, thus it is hard to see how there can be a direct correlation between hours worked and commitment to the job. Hakim's point is that since part time work does not present a challenge to the status quo (in terms of a primary self identity as a housewife, bargaining power and role in the household) then "[w]e cannot expect the expansion of part-time work to be the

catalyst for social and economic change" (1996: 178). A somewhat sobering conclusion.

The positioning of women/nurses in paid work under restructuring can be seen to be a highly complex and potentially conflictual site. In a web of care, devaluation, fear for jobs, professional values and shifting job requirements it becomes necessary that nurses somehow need to make sense of their lives, both professionally and in their private worlds. These conditions, that nurses themselves attempt to work through, are further explored with reference to the data gathered by interviewing fourteen nurses about their experiences of nursing work in the town. But first an explanation of the research strategies employed in the conduct of this research project is in order.

CHAPTER FOUR

Research Strategies

> Narrative identities are constituted by a person's temporally and spatially variable place in culturally constructed stories composed of (breakable) rules, (variable) practices, binding (and unbinding) institutions, and the multiple plots of family, nation, or economic life. (Somers 1994: 625)

This study is informed by critical feminist epistemological frameworks in which claims to knowledge are made. Within this overarching framework this chapter covers the design of the research study, the methodology and methods which I have used, both to formulate and ground this project, including data gathering. I hope to walk a tightrope between essentializing women as a group, victimising them anew, or, taking a relativistic stance in which the experiences of these women are just added into the melting pot of 'difference' and thus devoid of any notion of political investments.

Among the considerations within feminist critical theory is the challenge to traditional methodologies. Traditionally much research has relied heavily on a positivist paradigm derived from the so-called 'hard' sciences. This paradigm takes the view that information gained and produced by these methods produces 'facts' about 'reality' in so far as they are subjected to tests of reliability and validity. Indeed, while the results of such research carry some credibility in the scientific paradigm, there are serious critiques of this positivist approach which have called into question many of the basic assumptions underpinning this model.

The Challenge to Positivism

Feminist critiques of positivism are wide ranging and it is these that I have attempted to take into account in the design and practice of this study. Objectivity, a key feature of positivism, is much contested in feminist theory (see; Harding 1986; Longino 1990; Barwell 1994 among others). Sometimes called a 'God's eye view', objectivity is

assumed to be the pinnacle of good scientific research. Feminists and others have disputed this valorising of objectivity by claiming that we all speak from a "position" and thus we are all "situated" (see Haraway 1988). This positioning influences what research questions we ask, how we ask them, what our underlying assumptions are and so on. Thus, the deconstruction of claims to objectivity has allowed for the more transparent process of stating the positionality of the researcher. This awareness has opened the way for the feminist claim that much of what was assumed to be value free was grounded in the positioning, experience and observations of men. Women's experience, in the 'value free' configuration, was assumed to be the same as that of men or simply an irrelevant issue. It is much disputed by the above authors as to how far this project of the deconstruction of claims to objectivity should go. However, for our purposes here it is sufficient to be cautious of the limits of objective knowledge and to take account of the need to be reflexive regarding the position from which one speaks.

The production of knowledge is not in itself a simple process but rather it is one which opens many avenues of questioning such as what counts as knowledge, who gets to produce it (can women), and under what conditions. In other words, the production of knowledge is politically contested. For Lennon and Whitford, feminisms' most compelling epistemological insight is:

> the connections it has made between knowledge and power. This is not simply in the obvious sense that access to knowledge enables empowerment; but more controversially through the recognition that legitimation of knowledge-claims is intimately tied to networks of domination and exclusion. (1994:1)

My concern in this thesis is with nurse's experiences of restructuring which are explored by focusing on identity narratives. The notion of experience, and particularly women's experiences as differently situated in comparison to men was central to feminist standpoint epistemologies. These epistemologies emerged in order to attempt to address the absence or invisibility of women and their positioning from mainstream knowledge claims. Crucially, feminist standpoint epistemologies are based on the assumption that women's embodied experiences are different to those of men. Thus, this earlier feminist work attempted to place women's experience as the focus and a

method of grounding research (see Harding 1987; Harding and Hintikka 1983; Hartsock 1987) and "many feminist researchers assumed that they would find new and better ways to document the hidden truth of this experience" (Armstrong and Du Plessis 1998:104). Towards the late 1980s and into the 90s, this project was called into question. Experience it seems was not so simple.

Experience

The notion of experience as a ground for knowledge claims has been examined by a raft of authors who have highlighted different problems with claims based on experience. Scott, for example, suggests that any use that is made of 'experience' in which it is assumed to contain a transparent meaning "reproduces rather than contests given ideological systems" (1993: 25). That is, it presents no challenge to the status quo but rather repeats it. Scott would rather conceptualise experience, not as that which individuals have, but rather she would see that it is subjects who are constituted through experience (ibid 1993: 26). In Scotts's approach, experience becomes not the ground of our argument but that which we seek to explain. The position of experience thus shifts. From being a means of access to truth and reality experience comes to be seen as historically and spatially located, yet not to say fixed. Experience becomes that about which knowledge is produced and this process also historicises the identities it produces (Scott 1993: 26). The task then is to explore the discursive operations by which identities are negotiated. This process is, inevitably contested and therefore political. This strategy begins to address the contestation of the category 'woman'. To assume 'experience' is common to any group of women inevitably involves exclusions, although claiming this common experience has been politically useful at times. The challenge to the category woman came from those women who did not experience the commonality that was assumed. Lesbians and women of colour, in particular, mounted a challenge to the hegemonic notions presented as 'women's experience' by white middle class feminists.

The deconstruction of such categories as 'woman', the 'subject' and 'experience' which has been so much part of the poststructuralist effort has caused some concern. If the grounding of this work can not be situated within in a positivist paradigm or by

recourse to some transparent 'experience' of some category called 'woman', the question then that needs to be addressed is just where the ground for this kind of approach may reside. It has been argued that if all that remains is discourse, no 'real' things to hold on to any more (nihilism), then how can there still be a political project, since to deconstruct something led to the conclusion that it must be rejected. Butler carefully argues that to deconstruct something is not to dismiss it, but rather deconstruction is an essential step in the process of freeing the above categories from their 'foundationalist weight' and opening them to re-signification. This, for Butler, allows for permanent political contest which is the precondition for a politically engaged critique (Butler 1992).

The Research/Study Design

Positions

One of the ways in which qualitative researchers have sought to make the research process more transparent is the promotion of high levels of reflexivity on the part of the researcher. While it is vital that this process be carried out to the best of our ability, it is inevitable that it will be partial, since our knowledge of our motivations, exclusions, inclusions and blind spots is never perfect; as Mauthner and Doucet note, "we are undoubtedly influenced, whether consciously or not, by our own personal, political and theoretical biographies" (1998:122)[33]. This positionality "carries particular implications... for how we may 'hear' our interviewees, and 'represent' them in our writing up" (Ribbens and Edwards 1998: 5).

I, in a sense can be positioned as an insider/outsider within the context of this research. Although I trained as a registered nurse in the town in which I am conducting this study along with some of the people that I have interviewed, the route that I have followed since that time has not been even similar to any of the interviewees. I have done about five years of clinical nursing, some of which was part-time. I, in a sense lost clinical nursing for some of the reasons that the

[33] Furthermore, many researchers who are engaged in empirical work are located between the academic world from which a qualification may come as a result of the research, their private worlds in which they may often have a personal investment in the topic under investigation and the worlds of those whom they interview.

interviewees are currently grappling with. Perhaps I am best seen as an ex-insider and to acknowledge that I can identify with some of what the interviewees talk about but not all of it.

The act and process of fieldwork, in this case interviewing and observation of the field, while apparently simple, is fraught with potential and actual problems (see Oakely 1981 among others). While on the one hand interviewing can be a rewarding and rich experience, it is also a complex and contradictory act and the interview is one of the places that a power imbalance may be evident between the researcher and the researched. Although the power imbalance between myself and those that I interviewed was not as great as it may be in some research projects, I was conscious of a number of ways in which I may be perceived to be in a privileged position, most particularly because I currently live in a city. In hierarchies of 'place' the city is valorised and thus privileged. I was unable to judge if this point had an impact on the people that I interviewed but I will note that several people specifically noted that they liked their town and were very happy to be there. They valorised their place. I am also part of an academic establishment and I have been conscious of the potential problems regarding the academic/practical split which is alive and well in feminism and has certainly played a part in nursing in the past and may still continue to play a part in some quarters.

In some sense it is also the case that the researcher takes the interviewees' words away 'frozen in time' so to speak[34]. There have been a number of further changes at the hospital in the town since I interviewed the participants in this research. These further changes may alter what some of these nurses now think and feel about some of the issues on which they commented. However, it is easy to feel discouraged and indeed to wonder if it is possible to actually do something called feminist research (as a number of authors have wondered, Patai, 1991, for instance). Regardless of the potential problems it is still important, crucial even, to push on with eyes open for the things that we are still blind to as researchers.

[34] The process of discourse analysis should pull apart the notion that narrative can be frozen in time, since language is not assumed to reflect something called reality but rather it is that which we seek to explore and deconstruct.

Research Method and Sample

Interviews

I focus on in-depth interviews which give an opportunity to gain a more contextually rich type of data than simply following quantitative methods of data gathering such as questionnaires or surveys of some sort. That is not to say that such things as statistical data are unimportant but that they do not produce the richness of material that in-depth interviews reveal.

In spite of the potential problems with interviews they remain a rich means of learning by paying attention to the narratives of what things mean to 'real' people (however fleetingly). Thus along the lines which I believe are sympathetic to Scott's formulation of 'experience'(above), Somers suggests that it is through:

> narrativity that we come to know, understand, and make sense of the social world, and it is through narratives and narrativity that we constitute our social identities....all of us come to *be* who we *are* (however ephemeral, multiple, and changing) by being located or locating ourselves (usually unconsciously) in social narratives *rarely of our own making.*
> (1994: 606. Emphasis in original)

The task, for me, was to begin to tease out the often contradictory, complex, messy nature, of the way people have negotiated change in their worlds of paid work. Also to look at the discourses that have informed the various ways that people make sense and to perhaps gain access to the 'emplotted stories' (Somers 1994) that constitute identities.

With this notion of the function of narrative in mind fourteen nurses in a small New Zealand town were interviewed. All but one of the nurses have worked at the hospital during restructuring. Eleven of the nurses currently work at the hospital, with some working partly in the community and partly at the hospital. The hours that the nurses work per week vary from a casual nurse who works one day every few months, to those who work full time, with the majority being permanent part time staff. The interview process was fairly flexible in order to allow for particular peoples' areas of

concern or interest to be developed. This flexibility was, however, within the framework of the interview questions (see Appendix A).

Interviews were carried out in the town over four visits covering a period of several months in late 1999. The first contact was made to a person that I knew who still worked in the town and from there I used a 'snowball' method in order to gain more people to contact[35]. Interestingly I experienced some of the tensions of spatiality in the need to travel from my home to interview the people who had agreed to participate in the study. The level of planning required to provide care for three children and to be away from home for a number of days at a time needs no elucidation for those who do it, but it is almost never simply achieved. Something that many of the interviewees are intimately aware of!

The interviews where tape recorded and transcribed to allow for close and repeated attention to the content of the interview. A transcript was returned to each of the participants in order that they had a chance to withdraw anything that they may not have wanted included, and also to point out any areas that they were particularly concerned would identify them. They were all also asked whether they wanted the tape and transcript returned to them at the conclusion of the study or destroyed. Only a very small number indicated their preference. All of the participants have been given pseudonyms for the purposes of including transcript material in the thesis.

Data and Analysis

Initially the data was sifted through and organised into themes, following on from which two themes were identified and analysed in greater depth. Many themes which were identified could have been common to most nurses, wherever they were located. However, two themes, multiskilling and mobility, represented issues that I felt were more specific or intensified for Registered Nurses in a small town.

[35] The information sheet and consent form which I used are contained in appendices B and C respectively.

The method of analysis that seemed to best fit the type of data and my research purpose is that of discourse analysis. Although often hard to quantify, a discourse analytic approach positions data as a medium, rather than that which we collect. In Alldred's words:

> Research is recognized to be a practice of re-presentation, and 'findings' a re/presentation through a particular lens. This invites reflexivity about the production of the account. The participants 'voice' is seen as produced from what was culturally available to her/him, rather than from a private reserve of meaning. The fantasy of the authentic subject, one whose subjectivity is imagined to be independent of, or prior to, culture is rejected (1998: 155)

The discussion so far may begin to sound rather free floating and relativist. If relativism is "a way of being nowhere while claiming to be everywhere equally" (Haraway 1988: 584) then this would not do justice to a politically engaged feminist analysis. Therefore the issue of how this type of research is grounded needs to be addressed if the usual claims to validity (by reference to objectivity for example) can not be made. This type of research is less grand in its claims. Instead of making claims to universal thruths and theories, the task becomes much more modest, much more local if you like. Thus I make no claims with regard to all nurses or all towns or all women, but rather the task is to explore the cultural specificity (Fraser and Nicholson 1990) within which the research question is embedded. In terms of analysis and interpretation, Alldred citing Burman explains that "the point here is not to arrive at a unique and unambiguous interpretation, but to demonstrate that an analysis of power relations privileges some interpretations over others" (Alldred 1998: 158).

Interpretation itself is not a simple and apolitical process but rather one carried out by fallible, politically invested people. Feminist theorists have raised many questions about the process of interpretation and have suggested that more of the work of interpretation should be carried out by those who are participants in the research in order to attempt to deconstruct the assumption that interpretative authority 'belongs' to the researcher. In this instance I did not feel that it was possible (both in terms of time and expense) to have the people I interviewed play a larger part in the interpretive process, beyond the initial interview and checking over the transcript. I believe that at some point the person responsible for writing the project up (unless

there is to be joint authorship with the research participants) needs to do that. This inevitably involves a gaining or maintaining of control over the research product. DeVault adds a very interesting angle on this issue by suggesting that although she sees:

> Concerns about the ethics of representation, and attempts to equalize interpretive authority... [as] central to feminist methodological innovations.... [and she wonders] if they also reflect an unwitting collusion with ideological constructions of "woman" as especially moral or caring, or perhaps, a learned discomfort with authority that many women feel. (1999: 188)

This factor is another unresolved issue in feminist conversations around the process of research.

Ethical Dilemmas

After dealing with the more usual ethical issues in any piece of research, such as the process of informed consent, a number of ethical issues become more dominant when the geographical area of research is a small town. The problem of protecting confidentiality is not small when it is realised that the nurses work together and often socialise together. They are very familiar with each others speech patterns and I know some of them have discussed their participation in this project with each other. This in itself is not necessarily a problem, but it is a factor that may influence the research in a way that it may not do in any more anonymous setting. It has meant that I have not used a lot of data which in this small setting would immediately identify the participant. I could also not provide profiles of the people interviewed since this would also identify them to each other.

Since I did my nursing training in the town in the late 1970s, I had some familiarity with the area. I knew some of the people that I interviewed and this situation left me with questions about whether it would be harder or easier to carry out research with people I know rather than those that are unknown to me. If interviewees are known, then the interviewer goes into the interview with some 'background' be it shared history (however brief) or an ongoing friendship or acquaintance. Going into an interview situation where the people are not known to any degree by the interviewer

seems to me to present a different ground to work from. These are questions to ponder, rather than questions that have been answered.

Protecting the identity of the town, which I attempt to do at the request of several of the participants, is not a simple matter in New Zealand (Tolich and Davidson 1999) and I have found that this has quite a strong influence on what kinds of things I choose to use in the thesis. It may be that there are still things included that people may think that they can identify the town from. However, I have made my best effort to leave any kind of identifying information out. However, I personally think that the thesis would have been richer had I been able to name the area and to include more contextual features in order to 'situate' the town in wider New Zealand. In conclusion I think that any piece of research such as this will, inevitably, be a compromise between the desire to present as full a picture as possible of the research area and the imperative to maintain confidentiality.

In the following chapter I investigate the nurses' narratives. These narratives have been organised into themes which represent the ways in which nurses are being positioned and position themselves in the discourse of restructuring and the way it has affected their professional identity.

CHAPTER FIVE

Contextualising Nurse's Professional Identity

This chapter draws together the data that was generated by in-depth interviews of Registered Nurses. I had begun, following the impressions that I gained from a pilot study in 1998, with the assumption that the downsizing of the local hospital would have a bearing on professional identity, Further, that a shift in this identity would be precipitated as a result of changes in the nature of nursing work/tasks. Many of the concerns, addressed by the nurses that were interviewed for this project, are those which might be shared with nurses in cities (see *The Inside Story of the Health "Reforms": A Report of Interviews with Nurses* produced by the New Zealand Nurses Organisation in 1995). There were, however, some features which stood out as distinct from the more general concerns. It became obvious that the work/tasks had indeed changed and that rather than engage in low levels of specialisation, nurses were now encouraged to undertake multiskilled roles. One of the ways that nurses responded to the shift in work tasks and conditions was the consideration of mobility. I was interested in exploring the dynamics of the shift towards multiskilling and also the extent to which mobility (both moving from the town or commuting) was utilised as a means of protecting the professional identity by gaining access to alternative nursing work. It became clear that a number of domestic factors needed to be balanced with both nurses' need for paid work and the importance of a professional identity in their lives.

This analysis draws on feminist poststructuralist approaches. In chapter four I indicated that the task of the thesis was not to uncover the 'truth' of the experience of nurses in a small town. Rather, the task, over the next three chapters, is to attempt to make sense of nurse's narratives of their subjective experiences of their new positioning. My purpose here is to 'unpack' the web of discourses that compete in this site, (small town) and to construct meaning around how professional identity is enacted and contested in the light of health restructuring. Using discourse analysis, particular attention is paid to the workings of power relations. As Jaworski and

Coupland note, "The motivation for doing discourse analysis is very often a concern about social inequality and the perpetuation of power relationships, either between individuals or between social groups..." (1999: 6).

Having explored in chapter two how the public and private spheres are interdependent, it becomes crucial to look at the ways in which nurses are positioned in the domestic sphere. Thus a brief summary of the family configurations of the interviewees provides valuable context.

Family Configurations.

Most of the people that were interviewed for this study were currently married with children. Five of the interviewees had younger children. Thus, the life stage of the nurses differed; those with smaller children express more of the juggle that is required to participate in paid work and to take care of children. Hospital nurses work, in the main, one of three shifts each time they work, either 7 am until 3:30 pm; 2:30 pm until 11 pm or 10: 30 pm until 7 am. These are hours that would give many people headaches if they had to arrange childcare to cover these shifts. Nurses working in the community tend to work daytime hours, but of course some nurses did a combination of community and hospital work. There is occasional use of shorter shifts[36] but this is fairly unusual. Of those with growing or grown children, many had very good childcare arrangements when they returned to work many years ago; this included family members, paid caregivers, other nurses who shared care of each other's children, friends and partners. Some worked night duty so that they could be available for the children. There were issues with school holidays and sick days as would be expected. In many cases people had good support systems in place to deal with such times but it was all none-the-less a juggle and not without its problems.

The level of involvement partners had in providing care for children depended on a large variety of circumstances, and mostly to do with the types of jobs they themselves had. Many of the nurses described their partner's input positively: 'supportive' or 'great with the kids' or 'just takes over where I leave off'. Those with

[36] Shorter shifts are periods within a full shift, usually at particularly busy parts of the day.

much younger children with partners who have very demanding jobs perceived the situation to be rather more difficult. In some cases the partner spent some time out of town and this made it very difficult to work, given the shift work that is required and the age of the children.

In two cases the nurses earned a significant amount less than their partners. Incidentally, these people were also 'late mothers' who had had children in their late thirties having practiced as nurses full-time for many years before this. These were two of the people who were most discontented with what the work had to offer them at the hospital. These two nurses were previously working in a hyperskilled field before they came back to the town for their partner's jobs. Most of the other nurses had children when they were younger and had a break from nursing much earlier in their careers. Many were prompted back to work by family financial situation.

The close-knit nature of towns becomes clear in that most of the interviewees were either from the town and had married local people, or had come to the town on marriage. A minority had been away for extended periods and had moved back for a male partner's job.

Although the sample size is relatively small there are, never-the-less, some common themes that were identified in the nurse's narratives. The major themes that are repeated are:

1. A general lowering of job satisfaction.
2. A feeling of having been professionally de-valued.
3. Professional boredom with the type of work that remains at the hospital.
4. Dilemmas around the question of moving (out of town) or commuting for alternative nursing work.
5. Concern about the maintenance of professional skills in a downsized work environment.

The above themes are presented in this chapter in two parts. The first part explores the first three issues which are seen as outcomes of the restructured health

environment. The second part introduces the fourth theme; that of mobility. The possibility of mobility is seen to be one of the responses to the restructured environment. These issues are explored in terms of nurse's narratives. The fifth theme is discussed in the context of chapter six.

Job Satisfaction

The issues of decreased job satisfaction and professional de-valuation seem to result from conflict and tension between competing sets of demands. On one hand are discourses of professionalism which encompasses the knowledge and practice of a certain body of nursing skill and the sense of a discrete professional identity; on the other are the discourses of management which promotes efficiency, cost cutting and labour flexibility, both in terms of numerical and functional (multiskilled) forms. Yet sitting between these two discourses (professional and managerial) is the notion of nursing as a vocation.

Job satisfaction is notoriously difficult to measure, and, indeed, was no easier in this study. An enormous number of factors appeared to impact on levels of satisfaction, but some of the most crucial issues were those instances where professional and managerial discourses appeared to be in conflict. A process of, what begins to feel like, constant change due to different rounds of restructuring has been a major factor influencing job satisfaction. It seemed that it could be quite difficult to pay full attention to work when another round of change was occurring, or immanent, with the attendant shifts in expectations, conditions of employment, actual availability of employment and so on.

In terms of the actual work, among the most important issues were those around getting the work done in the space of time available. This condition is exacerbated by a shift to more acutely ill patients of increasing age and lower staff numbers, all of which contribute to a more intense environment. Many nurses felt that this could lead to a compromise in the quality of care that a patient received:

> *Some days you come home and you think, oh God, I wish I had a few more hours. And you sort of wonder, have you finished the job properly. You could*

> *have had extra time with so and so, but with the demands you can't do it and that's pretty frustrating actually.*(Rose)

Professional demands place an onus on the nurse to complete a task or duty in certain ways. Furthermore there is a responsibility to the staff coming on to the next shift who have clear expectations of certain tasks having been completed on the previous shift. A management discourse which focuses on efficiency and encourages nurses to work harder and faster can be seen to be in conflict with "care" as defined in the professional discourse:

> *And if we're not finished in time we're obviously not very organised and not very efficient...and people get very, very cross because they try really hard to give quality care and so they find that the quality's been compromised.* (Elizabeth)

Ruth's narrative also highlights the conflicting demands (management and professional) that she feels contribute to her sense of dissatisfaction in her nursing work:

> *You can't do all your proper nursing and I find that's what's changed a lot is they expect you to do a lot more and they've got no sympathy, they say, oh well, you just get on with it and do it. I find that I'm often coming home dissatisfied at the end of my day because I haven't achieved what I wanted to and I think you'll find a lot of nurses are like that here. They find they're not achieving what they want to. At the end of each shift they are going home disgruntled.* (Ruth)

Alongside this notion that the kind of nursing carried out on a shift does not always meet expectations of professional standards, is the broader issue of the position of nurses as professionals in the hospital structure.

Nurses as De-valued

During the latest round of restructuring at the hospital a number of very significant changes were made. Among these were drop in both pay and work conditions. Management in the last round of talks pointed out to staff that they were, in a sense, no different to workers at the Warehouse or Woolworth's (both large chains of retail stores) who worked at all hours with no penal time entitlement. This factor was noted by some staff with quite some indignation. This stance does not take account of the skills that registered nurses feel that they are entitled to be paid for and also the fact

that they provide twenty four hour cover, rather than working the odd late nights before Christmas as Warehouse workers might. Several nurses said they could understand that penal rates had to go but qualified this by saying that they should have a higher base rate of pay instead. For example Rachel:

> *They really should acknowledge the fact that people do work twenty four hours of the clock and so if they don't get penal rates then their base rate should be up a bit so that they have been compensated for the fact that they do that.* (Rachel)

It is interesting to note that not all hospitals have dispensed with penal rates[37], so it is a situational choice by management. All of the interviewees commented on this loss of pay and conditions, and most expressed great discontent about it. Most nurses felt that these losses were an assault on their skilled selves, as their narratives below reveal:

> R*esponsible, educated nurses ... were being put in the same slot as sixteen and seventeen year olds who work for six dollars an hour stacking shelves.* (Rachel)

> W*e're all pretty angry and frustrated really at what did happen, probably the monetary thing hasn't gone down very well with staff really, and we're doing exactly the same job. I'm probably down about six thousand a year, so people are pretty angry, but I've moved on. I think, lets face it, we've still got a job, lets move on. But it's not a subject that you want to bring up too often because there's still a lot of anger there and hurt.* (Rose)

> *Well, we're lucky to have a job I suppose here...I shouldn't look at it like that...like* [partner] *just looks at me and thinks oh well she's earning more* [than her partner] *so what have I got to complain about? But compared to teachers and police and things like that we're right down there.* (Elizabeth)

This management strategy to reduce pay and conditions seemed to both incense and scare nurses. On the one hand, being equated to a worker at the Warehouse or Woolworths can be seen to be an undermining of professional status, and on the other, there is a sense of fear that resistance to this loss of pay and conditions could carry its own dangers. For instance, attempting resistance as an individual can lead to concern that there will be repercussions:

---

[37] There does not seem to be a clear pattern regarding which hospitals have removed penal rates. They are not clustered **only** in urban or **only** in rural areas.

> *It makes you feel vulnerable, you try to be outspoken, but it may reflect on you ... like if we misbehave as such, that we're going to be penalised for it.* (Ruth)

This concern about 'speaking out' about poor pay and conditions may have contributed to the unwillingness on the part of the nursing staff to refuse the unpopular contract in which this latest reduction in pay and conditions is contained:

> *I really think that if we'd withdrawn services ... I mean, without nurses they didn't have a hospital, and they could have done it. But the girls were too frightened ... as I say, other people had student loans and dependants and things and they couldn't afford to take that risk.* (Jennifer)

The risk for many nurses must have seemed simply too great in the face of an unstable, uncertain, economic situation and job market. However, that is not to say that nurses are accepting and compliant to the extent that they ceased to be concerned about professional standards or the levels of satisfaction that their work gave them

Boredom

Alongside issues of pressure of work and feeling de-valued in terms of remuneration, about a third of the nurses expressed concerns that the work had become less interesting and challenging when compared to other jobs they had had, or to earlier employment at this hospital in its larger form. Sarah sums up what the change in the hospital has meant for her:

> *Then we were left with just one ward and it was horrific...it meant there was no challenge as a nurse. I suppose we still had coronary care and intensive care but you couldn't always guarantee that you were going to get in there, you might just be in the ward and really it just became like a re-hab. facility....We've got 30 beds and it's a mixture of paediatrics, acute medical, surgical re-habilitation ... and quite a lot of oncology and the HDU, which will have the myocardial infarcts. I suppose we have kind of adapted with the change as far as nursing goes, some duty's it's so unstimulating I think why am I doing this...* (Sarah)

Rachel concurs with Sarah in the unstimulating nature of the work, particularly on the ward as opposed to the HDU[38](High Dependency Unit):

> *The patients are lovely, I mean they are all lovely people, but it's very boring.* (Rachel)

---

[38] "The unit" in question is a small unit in which people, mainly, with myocardial infarcts are cared for.

Yet for Sarah there is still something about nursing which keeps her there in spite of the lack of challenge:

> *... but I know that I really love it, I love my nursing. I certainly don't do it for the money any more because there is no money, we're not getting paid enough, but that's another story. But I love the patients, the contact with the patients still. I can nurse the patient along and help to get them better. It's the concept of being a nurse - I still like that holistic thing. If I try to deal with all four aspects of the patient, I'll get that patient back to good health.*
> (Sarah)

Vocation vs Profession

Although not strictly influenced by the process of restructuring, the complex relationship that nurses have with their occupation (vocation vs profession) may be intensified in a restructured environment. In some ways the mobilisation of the notion of vocation may help nurses to carry on in spite of some very unwelcome changes. Perhaps it is part of their sense-making.

In chapter two the complex historical legacy of the nursing job that was seen to be a vocation, while also encompassing an ideological shift towards professionalisation was discussed. The fact that very few (less than a quarter) of the nurses that I interviewed had always wanted to be nurses[39] seems to challenge the notion that a nurse is 'born and not made', to borrow Simone de Beauvoir's term. Yet there persists, overtly in some of the narratives, this notion of vocation which seems to call forth the impression that a tendency towards this caring work is an 'inherent' part of the person's being[40]. This notion certainly has a correspondence with the assumption that nursing is 'women's' work, an extension of their, already entrenched, caretaking role in the family and society as has already been discussed in chapter two and three. For instance, Rachel, who is in her early forties and is aware of this idea of nursing which has been current in her working life, suggests that this is antithetical to it being perceived as a profession:

---

[39] Of the nurses who had actively wanted to pursue interests other than nursing, they had either not been accepted into training, changed their minds or were strongly discouraged (usually by parents). Some of these interests ranged from farming, to veterinary science, to teaching, to becoming a chef. Some of these occupations would not have been the most mainstream career choices for girls in the 1960s and 1970s.

[40] In keeping with other vocations or 'callings' which have been very gender specific, for instance the priesthood, nursing has broken this pure attachment to one gender just as the priesthood has, at least in some religions.

> *I don't know if it* [nursing] *has ever been recognised as a profession, no, it has recognised as a calling, like going to be a nun. If you were a nurse you were a nice person, a nice girl and you were good and caring and you were a good chap.... but the whole society has changed though hasn't it really.* (Rachel)

Being a nurse, as a calling, is equated with 'goodness', 'niceness' and 'caring', whereas being a nurse, as a profession, requires that the practitioner is competent in a certain body of skill. Although Rachel's image of nursing as a calling is in the past tense, Elizabeth indicates that the notion may not be so far away from the surface even now:

> *I feel sometimes that nurses are more undervalued and probably have to relate that more to the wage packets...someone said to me the other day, we're working harder than we ever worked and we're getting what we got ten years ago, and you feel like there's this Florence Nightingale understanding that we all have to be committed and wonderful and never complain and just work hard and be grateful...but sometimes I do think that nursing is a bit of a vocation...I mean people do love it don't they?* (Elizabeth)

The role of "nurse" also escapes the confines of the hospital or work setting in the town so that the nurse may sometimes feel as if she is not off-duty when outside of work hours. With a downsized hospital where most patients are in one ward there is strong likelihood that nurses will be recognised by patients outside the hospital setting. In a sense Nurses are more public figures here than they might be in a city where a degree of anonymity is common. This situation can be very positive for nurses with patients expressing gratitude or pleasure at the care received by them. However, this can also mean that the job never feels like it is over for the day.

The Nurse as Public property

About a third of the nurses noted that the size of the town increased the amount of knowledge that they had about patients compared to what you would have in a city. For instance, knowing the circumstances of someone's home environment may sometimes have an impact on length of hospital stay (depending on resources):

> *I feel that I know the hospital so well, I sort of know how it ticks. I think being a small town everyone knows everyone and even with nursing the patients you often know their family background, who they are, and that just helps a wee bit.* (Rose)

Though this may be a positive thing for the patient, this very same local knowledge and local profile can make the nurse 'public property'. For example it becomes difficult for nurses to move around the supermarket, or other social situations without seeing people that you have nursed and be potentially 'available' for discussions regarding treatment, care, or advice:

> *I'm very circumspect when I'm out somewhere, in that if I go to a function in the town (and I'm doing less and less of that)... drinking is a no-no. I just tend to socialise privately... but you get tired of being that role, there isn't a life as well as the role.* (Lisa)

This point represents a clear example of the blurring of the boundary between the public and the private roles and the public profile of the nurse. However, when asked what she liked about the town, Jennifer responded that she liked its smallness but suggested that:

> *It's an intimacy, and yet that's also one of the things I most dislike about it...you can't sneeze without being told about it the next day.* (Jennifer)

This type of mixed response was not uncommon amongst the nurses. The very same things that are seen as strengths of a town can also be weaknesses; smallness can be comfortable, containable, friendly and supportive, or it can be claustrophobic. Nurses are also in an ambiguous position regarding decisions about mobility. In the context of the restructured town hospital mobility is one of the options that has been considered by nurses in response to their altered job tasks and conditions of work.

The Dynamics of Mobility

The issue of women's occupational mobility is a particularly salient issue in this town location considering the small size of the job market and the expressed discontent that many people felt with their current work. Since there is only one hospital in the town and limited opportunity for other nursing work in the area, moving out is one option that almost all of the interviewees have considered.

With the exception of one, all of the nurses that were employed in the town and were interviewed for this study perceived that they could not make a decision to travel or move for work independently of family environment. In this way, professional identity can be seen to be enmeshed in personal relationships and family

configurations, such that no decision will be easily made, even in the face of discontent with work.

All of the interviewees had considered mobility in one form or another. Many of the interviewees indicated that they would commute for work and many also indicated that they had considered moving out for work, or were actively currently considering it. Patricia, for instance, weighs up the factors in moving for work and concludes that domestic and family care are factors which continue to play a major role in a decision to move out of town:

> [Partner] *and I have often talked in the last year about shifting because of my job situation and then when we get down to the nuts and bolts of shifting it comes up with, you've got your friends here, you like the lifestyle, our* [children are entering important years at school] *you've got all these things and how would they adapt if you shift is the other question and the fact that they're doing ok at school...* (Patricia)

Several women with teenage children expressed concern that if they commuted to work in another centre then they would have to stay away overnight. Patricia notes that if she worked in another centre:

> *My argument with that is if you did that you would probably have to stay there two nights to do three shifts and I've got teenage kids and I don't know if I could balance that with the kids.* [Partner] *and I have talked about this and probably if it came to the crunch then we would probably shift.* (Patricia)

Similarly Ruth indicated that even though commuting was an option for her the situation was not simple:

> *I've thought about going to* [the city] *...cutting back and doing three days a week which, pay wise, would probably be the equivalent to what I am working here....But then there's the thing that I really don't want to start being away from home at night while my kids are...well any time really. Even though I'd try and get an afternoon, two afternoons and then a morning so that I'd only be away two nights. I just find that the ages that my kids are...coming in to teenage years and things like that that they need both parents around really.* (Ruth)

Ruth has also considered moving for work. The future of Ruth's partner's work has also been uncertain, hence she notes:

> *We might be forced to move and that's an option that we've got to look at, we might not have any other choice but to move and I think we are very open about that. We know that's in the back of our minds, that possibility.* (Ruth)

In some sense moving for work would seem less disruptive than commuting for work if it required an overnight stay, however, not all of the nurses thought that travel for work would involve this. The fact that both Ruth and Patricia thought that they would need to stay overnight may reflect the number of days that they would need to work in the other location in order to maintain their current income levels.

Those nurses whose children had left home seemed to be more concerned about other factors should they consider moving or travelling for work. For some of these nurses, a more crucial factor was the age of their partner and the likelihood of him gaining employment if they left the town. These concerns about moving out of an existing job by choice would appear to have some foundation. History professor David Thomson is quoted as reporting that "economic growth, however vaunted, doesn't make very much difference. Middle-age employment has shrunk across all the developed OECD nations, whether their economies are growing or stagnating" (cited in Ansley 1999: 17). Many of the men in question would fit this 'middle-age' category and an attempt to protect the job and income that you have can become much more of an issue when the differential costs of town and city living are taken into account.

The Expensive City

The cost of moving from a small town to a city are substantial and very obvious in the differential costs of housing. Ruth was not alone in pointing out that in spite of local job insecurity, being mortgage free gave her and her family a degree of security:

> *We're mortgage free here, whereas in* [the city] *we'd have to take out another mortgage which we don't really want to do at our age.* (Ruth)

However there is a further twist to this already complex situation. Many towns rely on one or two major employers (which are themselves vulnerable to closing or relocation to cheaper pools of labour) and this in turn increases the vulnerability of these nurses who, in many cases, earn half or more of a households' income. The implications of major employers either closing down or leaving for greener employment markets

presents some very obvious problems. If the town looses other major employers and downsizes at a faster rate then, for example, property values will drop:

> *The value of my property will go down considerably ... this is a huge debt and so the opportunity to escape will be lesser.* (Lucy)

Should property values drop and, for instance, a partner's place of work close, then it becomes even more difficult to relocate to a larger centre since you would have less capital to take with you. This climate of employment instability, is one in which many nurses tolerate unpopular management strategies since many of these people cannot afford to be without paid work and are constrained from moving out because of a myriad of family and financial factors.

Despite the constraints encountered by them, it is not the case that all people want to live and work in cities. In the process of privileging the urban and assuming that it is 'the place to be', it is important to note that this is not universally accepted. Patricia puts it bluntly:

> *I'm not a city person.* (Patricia)

Elizabeth also indicates that she feels sad that towns like this:

> *shrink and shrink and shrink and all of us will be expected to live in the city, which I don't know is such a wonderful thing.* (Elizabeth)

Lisa indicates her attachment to the landscape:

> *I like this land....I like the landscape, I feel this is where I live, this is where I want to be.* (Lisa)

The problematic issue of wanting work in the place that you want to work is a subject dealt with by Scott (1995). Scott concludes that "due to constraints on local development in a globalising market-led economy, there will not be enough job opportunities available in the formal sector of the economy to provide paid work for all who want it *in the place that they want it"* (1995: iii). A somewhat sobering conclusion for those people who are attached to *place* for whatever reason.

What is to be made of all of this? Against a background of discontent with the current conditions there are clearly some factors here which would be shared with nurses in a city environment. Yet the specific conditions of restructuring in the town environment have meant that there is little ability to specialise as a nurse and the bulk of the town nursing work now happens in one multipurpose hospital ward. This manifestation of the drive towards increasing flexibility of nursing staff by management and the attendant reconstruction of nursing skill which this shift entails are explored further in chapter six.

Both flexibility and mobility are seen to be promoted as central attributes of the contemporary worker. Yet the focus here is a little different since mobility (in particular) has been seen to be something that employers *required* of their workforce. However in this instance it is the workers/nurses who consider moving or commuting for work when their employers would rather prefer that they remained immobile. The issues of mobility for women workers are complex, since they have often been assumed to occupy secondary income earning roles and hence not be in a bargaining position in terms of relocating for work. The gendered dynamics of mobility are further explored in chapter seven.

CHAPTER SIX

Promoting Flexibility: From Specialisation to Multiskilling

> [Nurses] are the workforce that would have to be invented if they did not already exist.
> (Lundy 1996: 170)

In the previous chapter the narratives of the nurses who took part in the study were examined and some of the tensions that the nurses felt as a result of the shifts in the content and availability[41] of nursing jobs were identified and described. In this chapter the promotion of the notion of flexibility by management, particularly in terms of the shift towards functional flexibility, is analysed by examining how power relations are played out between nurses' discourse of professionalism and the discourse of management.

In order to explore the dynamics of functional flexibility or multiskilling, it is important to examine the ways in which nurses frame their narratives of skill and the role of skill in a professional identity, since the marking of a specific group of skills as belonging to a particular professional group is one of the ways that an attempt is made to secure professional status. The perception of the skilled self is crucial to professional identity. Thus the broad notion of skilling, which includes discussion of boundaries around skill, deskilling, and multiskilling is analysed.

Analysis

Flexibility

Flexibility, that catch word of the 80s and 90s, seems to be a key focus in a management discourse which is heavily structured around the current competitive market model in health care delivery. As Callaghan notes:

> Throughout the 1980s, then, the concept of flexibility emerged to sum up at once both the nature of change in the labour market which had been caused by economic restructuring and the change in the nature of labour market participants and their work which would allow economies to capitalise on such restructuring. (1997: 3)

[41] Although job 'availability' is not discussed overtly by nurses, the very fact that some indicated that they were scared to speak out in case they were penalised indicates some concern regarding availability of jobs.

Thus from government policy to the 'shop floor', flexibility has been that which 'we' need to aim towards. For example, in a report by Bill English, the Minister of Health in 1998, it is stated that legislation affecting the health workforce was "being examined to see if health professionals can work in new areas, in more flexible ways, and ways that meet community needs more closely" (English 1998: viii).

Flexibility has been implemented in the small town setting in both numerical and functional ways. In numerical terms, there has been a gradual reduction of full time registered nursing staff, and at present there are only two full time registered nurses. There has also been an increase in part time and casual contracts for registered nurses. Although the use of numerical flexibility usually leads to the formation of a 'core' (full time) and 'peripheral' (part time and casual) workforce (Atkinson and Meager 1986), it does not seem that the part time nurses are 'peripheral' in the usual sense, but rather, appear to be part of the core. In other words, the part time nurses' jobs do not appear to differ in terms of pay and conditions, however in a larger hospital part-time working would be very likely to have an impact on career development[42].

In contrast to numerical flexibility, functional flexibility is evident in the concentration of most of the hospital patients into one ward and the corresponding expectation that nurses will meet the needs of a diverse range of patients in one ward setting. It is ideally expected that nurses will also be able to cover the High Dependency Unit and Accident and Emergency Department when necessary. Nurses are required to mobilise multiple skills in order to function in the new environment. The expectation of functional flexibility, which is also identified here as 'multiskilling', raises questions about the ways in which skill itself is being reconstructed in this way by management.

Skilling: a contested terrain

It is not clear, and further it is hard to quantify, just how nurses construct a notion of skill. Wicks found, when having difficulty gaining responses from nurses in the area

[42] Opportunities for career development are relatively limited in the town environment.

of skill, that "the discourses around skill were, in a sense, woven into a total picture of work and knowledge" (1998: 145). The nurses in this study spoke of skill in a number of ways, although often not directly. Skill was spoken of in terms of knowledge, and identified as something that could be 'watered down' or lost. Significantly, skill is seen as tied to confidence and experience and providing job satisfaction. Skill is seen, variously, as a benefit to the work place, as something that requires frequent practice, that which is not acknowledged in pay and conditions, as something that can be learned from colleagues, with an academic and practical component, a bargaining tool, multiple, and as beneficial to the individual to maintain. Accordingly, skill is a complicated entity, one which results from the intricate workings of relationships between different actors rather than being simply a set of attributes as we might at first suppose. As Crompton et al. note:

> skill structures are to a very substantial degree socially constructed. The way they are defined is affected by employer beliefs about the effectiveness of different forms of work organisation, the capacity of the organisations representing employees to influence skill classifications and the characteristics of educational systems which are themselves influenced by the policies of national governments. (1996: 10)

In spite of the awareness that skill is complex and hard to define, a number of nurses were clear about what activities were **not** nursing skills as this is evident in the distinction between nursing and non-nursing duties. For example, 'giving out cups of tea' and 'gathering in meal trays' on the weekends clearly did not fit with their perceptions of themselves as professional nurses. Rather it can be argued that the irritation expressed at being required to take on these types of perhaps more menial and 'domestic' tasks reinforces the nature of the professional discourse, which is partially concerned to gain distance from the 'domestic' aspects of care work that have at times been part of nursing[43].

[43] The nurses in this study were not alone in their identification of tea making as a non-nursing task. In 1998 a New Zealand nurse refused to make tea for doctors at a top London hospital. This action was reported in the British and New Zealand press. The nurse, Rebecca Hassall, is reported to have said that she found "the task offensive, especially when she had been taught in New Zealand that nurses were professionals and part of the medical team" (Christchurch Press 23 July 1998: 2). The New Zealand Nurses Organisation in the same newspaper article is reported to have said that "making tea or coffee was highly unlikely to be part of a nurses job description".

The way the nurse constructs the skilled self can be seen to rely, to some degree, on the identification of some tasks as not appropriate to their skill levels. Appropriateness to skill level needs to be pushed a little further. Interestingly, it is not only the 'domestic' tasks which could be carried out by nurses aides that are said to be non-nursing skills, but also skills which have previously been carried out by highly trained specialists in their field, for instance pharmacists. Nurses "have done (and do) work which could be considered the province of cleaners, dietitians, porters, clerks, secretaries, ward housekeepers, receptionists and doctors" (Beardshaw and Robinson 1990:8 cited in Davies 1995: 91). The ordering of drugs, for example, was cited by one nurse in this study as a non-nursing task. This task would have been carried out by the resident pharmacist prior to the disestablishment of that position during one of the waves of restructuring. Perhaps ordering drugs is one of the Pharmacist's tasks that was later deemed to be relatively 'unskilled' and therefore able to be carried out by almost anyone. It seems, then, as if there is a bounded body of skill, although hard to define, which encompasses the work of the registered nurse. But the question of how much of this body of skill is specialist and how much of it is generic remains open for discussion.

Specialisation

During the process of professionalisation nursing work has become more specialised. For the nurse, specialisation allows the gathering of in-depth knowledge about predominantly one area of the body or organ system[44]. In a large hospital most staff specialise in either medical or surgical nursing. Within these broad categories staff often specialise within these specialties, for example, cardiac or orthopaedic surgery or respiratory or endocrine medicine; yet in this town setting there is no such demarcation between specialised areas. Some degree of specialisation along broad lines occurs at the hospital, for example, some people work predominantly in the ward, some in accident and emergency and some in the small High Dependency Unit (HDU). One nurse, after a period of about twenty years away from the town explains the significance for her of a specialty which was gained at another hospital and

[44][44]This may be at odds with the debates current in feminist and other literature regarding the need to look at the body as a whole, however, this discussion is beyond the scope of this thesis. I am, however, aware that this argument could be open to critique in these terms.

practiced for many years. It is so much part of her identity as a nurse that working locally is not an option. Instead it is the specialty and not generic nursing that she desires:

> *I consider it* [nursing] *to be a huge part of who I am, in that now that I'm not practicing, it took a lot of getting used to. It was almost like you think of your body image, it was part of me, so where was it, that whole part of me, where had it gone to? So it's taken me probably two or three years to come to terms with the fact that I can't practice....I could, but the conditions are so hard for me to get from this small town to a bigger town to do the particular type of nursing* ***that I specialise in****, so I had to take different steps to cope with that in my head really.* (Denise) (Emphasis mine)

This would suggest that there needs to be a 'fit' between a person's perception of their professional identity and the work available. However, this was not the case for all of the interviewees. In spite of finding that there was 'no challenge as a nurse' Sarah also expressed a preference for a specialty area of work which she is able to practice at the hospital but in a more limited capacity than was the case ten years ago. She never-the-less still identified a 'fit' that seems to work for her by saying that she still loved the concept of being a nurse, in spite of the lack of challenge. It seems likely that there is an element of the notion of nursing as vocation in the positive light which is cast on 'the concept of being a nurse' in the face of professionally unsatisfying work; yet, Sarah was also seriously considering relocating for the sake of maintaining her professional identity. On the other hand Denise could afford to decide not to work locally, whereas Sarah, who was clearly the main breadwinner in her family, would have had less chance to make that decision.

Even though there is an increasing trend towards specialisation, particularly in bigger centres, there are those for whom being unspecialised and not being attached to one area is actually preferable. When the hospital was larger Elizabeth was not really attached to any particular area:

> *I didn't even work in a ward. I just always used to relieve a lot, so you sort of got used to being able to move around, do whatever you have to and I still enjoy doing that heaps.* (Elizabeth)

It was noted in chapter two that it is the more technical (and usually the most specialised) areas of nursing that are seen to be the most privileged. Indeed it is often

these areas by which all of nursing is judged. The loss of ability to specialise to any degree at the hospital raises questions about the status of the nursing work that remains. Indeed, in some ways it could be argued that the work has become de-skilled.

Deskilling

Sociological literature has included much discussion of the thesis of de-skilling as it relates to work practices, most notably Braverman (1974). Though Braverman's deskilling thesis has been widely critiqued (see Gallie, 1996; Lewis, 1995; Attewell, 1987; Form, 1987; Crompton and Jones, 1984; Wood, 1982), it is never-the-less an important concept to take into account in the context of the particular problematic discussed in this thesis.

For some of the nurses there seems to be a perception that their jobs have been deskilled in that the skill level and tasks are less challenging and more routine than was previously the case. For those nurses who predominantly practiced surgical or operating theatre nursing, there is no longer a 'space'[45] for this group of skills, and for nurses whose area of specialty was accident and emergency the work has been scaled down. As illustrated in the nurses narratives their jobs had begun to 'lack challenge', 'become boring' and 'unstimulating' which seems to lend credence to the thesis of deskilling.

A perception of deskilling may present a threat to the professional identity, particularly if the notion of nursing as a predominantly specialised occupation, which is often judged in terms of its most technical areas is borne in mind. However, the distinction between 'hyper' (those nurses working in highly technical, privileged areas such as Intensive Care) and 'deskilled' (those nurses working in more general, routine environments), is not terribly helpful in that it appears to ignore the complexity of nursing skill. Thornley suggests that "concepts of 'human capital', 'flexibility' and 'deskilling' are rooted in the idea that skills are objectively quantifiable" (1996: 161).

[45] Thanks to Dr Nabila Jaber for this idea.

Skills in nursing may indeed be very hard to quantify, since some suggest that "good nursing [is] rather like invisible mending - much of it [can] not be seen" (Royal College of Nursing Report cited in Davies 1995: 146). In this age which equates seeing and observing with knowing and quantifying, then this is inherently problematic. That does not mean, however, that nursing skills do not exist, it may rather indicate that our means of judging them are limited in some fundamental way. This could be predominantly to do with the 'care' component of nursing work which can defy definition or quantification and perhaps the word 'skill' conjures too many associations with a professional project which predominantly fosters an "instrumental attitude towards work, at the expense of the expressive" (Waerness 1992: 223). However, as we saw in chapter two, nurses somehow manage to juggle the instrumental and the expressive in a hybrid construct.

So, although in some ways it could be argued that the nursing jobs at the hospital have been deskilled, this notion does not adequately capture the situation. In a critique of Marx's views on the labour process Sturdy et al. point out that "Marx underestimated the degree to which the tension between deskilling and flexibility could be managed" (1992: 2). Although deskilling is not usually part of the rhetoric of flexibility it seems that another hybrid construct operates in the town hospital setting. Nurses' jobs have become relatively less specialised and thus more routine which seems like deskilling. Under the new form of management nurses have also been expected to broaden their skills to cover a wider variety of patients than they would have had to attend to in the past. This broadening of skills is argued to be an instance of multiskilling, though not in a conventional sense. Bradley (1999), for instance in her discussion of functional flexibility also found that some of her respondents experienced change in their workplaces in this hybrid way; that is, jobs seem to be at once deskilled and multiskilled.

Multiskilling

The notion of multiskilling was introduced in chapter three in the context of the discussion of functional flexibility. This type of flexibility is seen by some

commentators (Piore and Sabel 1984 and others) as being a positive shift for labour in the sense that multiskilling has the potential for workers to increase their range and level of skill. However, if functional flexibility is introduced at a time of cost-cutting then workers may refuse to implement it as a response to cuts (Walby 1997: 75).

In a document prepared by (accounting firm) Coopers and Lybrand for the Central Regional Health Authority it was indicated that 'multiskilling' was basically a requirement for those nurses in smaller and rural areas in New Zealand. In fact Crown Health Enterprises:

> were advised to staff health centres providing labour and delivery services[46] and other inpatient services with registered nurses who are also registered midwives. Such staffing enables flexibility to provide care for all inpatients irrespective of their conditions and enables nursing staff to be fully utilised which decreases costs. (1996:7)

Being both a registered midwife and a registered nurse is a rather wide variety of skill to have and practice[47] and it would be interesting to see how much success there has been in recruiting this level of multiskilled staff. Even though the nurses in this study are not as yet required to be midwives as well as general nurses, since midwives remain in employment as a separate entity at the hospital, a management strategy in recent times included a determination to have all staff able to work in any of the other areas or roles available. Anna comments:

> *Everybody is able to work in the ward, there's a limited number that work in the unit and an even more limited number of those who do duty nurse*[48]*. Their* [management's] *intention was to get everybody able to do everything.* (Anna)

Yet there has been some staff resistance to this strategy, and we are reminded of Walby's comments above:

> *those that didn't want to work in the unit made no effort to actually go there, they were quite happy to stay in the ward.* (Anna)

Although it is easy enough to understand that there may be resistance, given what has been discussed about specialisation, to working in areas other than those where you

---

[46] Labour and delivery services in this quotation refers to labour and delivery in childbirth.
[47] This also begs the question of how this fits with the most recent construction of midwifery in New Zealand.
[48] The role of duty nurse encompasses a more supervisory role than most of the other positions.

feel your preference or expertise lies, it is also the case that **within** the basic ward setting a relatively wide range of skills is required of nurses when compared with the situation, say, ten years ago.

In this hospital setting, in which most of the patients are in one ward with a few patients accommodated in a small High Dependency Unit, the result can be a particular challenge for the staff who are expected to provide nursing care for a wide range of patients in their daily practice. The needs of patients could be as diverse as those for a child with asthma, an elderly person dying of cancer, a person being observed for signs of bowel obstruction and a person recovering from a fractured femur. Rose, for instance, indicates some of the difficulty she encounters:

> [I find it] *not great really, especially if you've got a palliative care in a side room with a wee kid screaming away down the ward or something. It's not satisfactory in this set up.* (Rose)

The conflicting needs and demands in this environment of 'multiskilling' are very obvious, with, for example, a patient receiving palliative care needing a calm and peaceful environment, whereas the needs of a sick child are rather different. These two types of patient are not, in bigger settings, nursed in close proximity, or by the same nurses. The range of patients to be found in the ward is more broad than that which would be found in most city hospital wards and is more broad than these nurses have had to cover in the past.

The difficulty expressed by nurses in meeting the needs of so many different kinds of patients in one ward, indicate a conflict between what management expects of the staff and what nurses feel is 'quality' nursing care. Some of the issues here are shared with nurses in cities, in that many nurses complain of not having enough time and staff to deliver what they consider to be appropriate care. But the phenomenon of a broad range of patients in one ward is more distinctly a 'town' issue. Indeed, Ruth notes the surprise that nurses from other areas express at the range of knowledge that town nurses have:

> *I think that a lot of the study days that I've been on, a lot of people say, from bigger areas, gosh you guys are very knowledgeable. But we've had to be, we've had to cope, we have to be.* (Ruth)

Ruth's narrative also seems to carry an element of the notion of vocation in her use of the terms "*we've had to cope*"; yet it also indicates the professional imperative to gain the knowledge needed in a particular clinical situation, in her use of "*we've had to be* [knowledgeable]".

In one sense this broadness may be perceived to be a challenge and an opportunity, as Ruth notes:

> *I've probably learnt a lot by being multiskilled and being put into situations that I thought I would never ever be put into and that happens a lot here. We get into a situation where it can be quite dangerous and we've had to really think quite hard about how you're going to deal with this situation. I've probably grown heaps in some ways since I've been here, probably more so than if I'd stayed in one specialised area.* (Ruth)

Yet considering the way that the most technical and highly specialised, intensive, or critical care areas of nursing are seen to be the most prestigious and skilled (Thornley 1996), then a nursing job that is generalised rather than specialised may be de-privileged. If this model which utilises the hyperskilled area of intensive care as the most skilled work area were to be applied to the town in which the study took place, then many of the hospital jobs would appear to be deskilled, since the majority of the work is of a general, rather than specialist nature, and thus can be seen to be **relatively** 'low tech'. Care of older people, for instance, is often perceived to be 'low-tech' work.

In a general ward there will inevitably be a fair number of elderly people. Although in the past there has been a number of, what were termed, 'long-stay geriatric' patients in public hospitals, particularly in small towns, this is no longer the case. The general state of patients in most public hospitals is more acute than it was, say fifteen years ago and hospital stays are also shorter, even in towns[49]. Thus, there is a **reason** for the people to be in a hospital rather than a nursing home or at home. Further, not all of the patients are elderly. Cancer, for example, does not completely discriminate

[49] Alongside lower numbers of hospital beds, shorter hospital stays, and an aging population, there has been a corresponding rise in the number of nursing homes in most areas, including cities.

by age and neither do heart attacks. But, the point to be made here is the possibility that nurses who predominantly work with elderly people whatever their medical needs are seen to be marginalised in terms of how they stand professionally amongst their colleagues in more specialised areas[50]. Although this issue may not seem to be of great concern for those nurses who wish to remain at the hospital, there are in fact some professional issues which have an impact on nursing practice in the town. In the context of this it is important to explore the dynamics of the maintenance of multiple skills from the town location. Furthermore maintenance of standards of education and practice has some relevance in the sense that about half of the nurses indicated that they were afraid of 'loosing' skills (the key indicator of professional status) if they continued in this environment:

> *It's getting to a stage where a high percentage of our patients in the ward are elderly and I sort of feel that I'm loosing my knowledge. I feel that I need to go elsewhere to maintain that.* (Ruth)

Ruth's narrative indicates a professional tension in that she is suggesting that moving out or commuting may be the only ways to protect professional knowledge.

Maintenance of multiple skills.

The maintenance of skills is a complex issue in the small-town setting, with many on-going education courses requiring travel. Accessibility to education and training is simply more easily achieved in the urban setting. With the pending introduction of Competence Based Practicing Certificates, which require a minimum of seventy five hours of professional development relevant to the nurse's practice over a five year period, accessing ongoing education will be an important issue.

The introduction of Competence Based Practicing Certificates represents a departure from an old system whereby once a nurse is Registered, then s/he is theoretically always able to practice. The system which will be introduced in approximately 2002[51] will require a nurse to demonstrate 'competence' (See Appendix D) before being

---

[50] An example of this occurring in another field is that of the situation of the 'general practitioner' in medicine who has less status than the medical 'specialist'. The comparison ends there however since general practitioners are, in the main, able to carve out a very good living, either because of, or in spite of their generalist status, in a way that is not possible for nurses.

[51] From personal communication with Nursing Council of New Zealand's Registrations Adviser, Donna Gordon.

issued with a practising certificate[52]. Part of this process is the assuming of full responsibility for one's own practice:

> you are responsible for seeking opportunities to learn and to maintain the level of your competence in the interests of patient and client care. You need to choose activities to meet *your* needs in the context of *your* practice. These may be within your work environment or within a tertiary education institution. (Nursing Council of New Zealand 1999: 9. Emphasis in original)

Many town nurses worked out what they thought they needed and wanted in terms of professional development and then tried to work out how to get it on a case by case basis. Lucy notes:

> *Sometimes people will say...I want to go to this paediatric study day or this CORD* (Chronic Obstructive Airways Disease) *study day orsomething like that. And I think, and believe that the time's coming now where we actually have to go and ask even further.* (Lucy)

Nurses are already taking responsibility for their learning needs in this way, and are sympathetic to the need to keep skills and knowledge up to date. As Rose says:

> *Gone are the days when you could go to work and just sit back and forget your ongoing education because things are changing so much you have to do it for your own safety really, and knowledge... I think you are responsible to do your own ongoing education. It's for your own good really.* (Rose)

There are some potential problems identified in this scheme. Firstly, if an individual nurse is responsible for identifying their own learning needs it is assumed that each nurse is aware of what the learning needs are. It is sometimes the case that 'you don't know what you don't know' and some nurses may, therefore, be unable to identify learning needs. In a personal conversation with one of the interviewees, she indicated that until she started to study towards a Batchelor of Nursing degree she did not know what she actually **needed**. She felt that it would serve to enrich her practice by bringing her up to date with new developments in nursing knowledge, although she was unaware of this when she started. Secondly, in a general, as opposed to a specialist, work role the sheer breadth of courses and types of education required in this general environment needs more than passing consideration.

[52] Nurses are required to hold a practising certificate in order to practise as a nurse. The certificates are renewed annually.

Management input.

The consultation document on competence based practicing certificates for registered nurses indicates that there is role for employers in assisting the implementation of competence based practicing certificates. The document notes:

> Employers have a role to play in providing the conditions which ensure that the standards can be achieved, in deploying into areas staff with the appropriate knowledge, skills, attitudes and judgement, and for monitoring the practice of employees. Such action towards quality improvements is imperative in the interests of the consumers of health and disability support services. (Nursing Council of New Zealand 1998: 7)

It would seem that the changes to nurse's practicing certificates may stimulate a more coherent response from management regarding nurse's professional development than is currently the case in the town. For instance, nurses seemed to have widely varying views on what part management was prepared to play in continuing education. If there was a management policy on in-service education and professional development, both in terms of availability of study leave and payment of course fees, then the staff that I spoke to did not appear to be clear about what it involved.

Placing all the responsibility on the individual for identifying and accessing relevant and necessary learning can be seen to be, at least potentially, problematic. Furthermore, for those who had managed to gain access to courses relevant to their work some felt that even with the knowledge gained from the courses, they were not able to get enough practise in order to consolidate skills and knowledge. While some skills are used very frequently at the hospital, others are only needed occasionally and it is this group of skills that are harder to maintain in small environments. Jennifer, for instance feels she does not see enough (throughput) patients to maintain her skills:

> *I'm not getting the throughput....it isn't enough to keep me current and we don't have the equipment* (Jennifer)

Ruth felt that a course was not worth doing since she felt that she would be unable to utilise the skills gained from it often enough to make it worthwhile:

> *I have been asked to do the emergency trauma course but I don't do enough A&E work. As it is with A&E these days you don't get the same amount of patients in because if they have a car accident the helicopter comes in ... and they don't come to the hospital now.* (Ruth)

Jennifer also noted that she felt that when the 'edge' goes off your skills then your confidence also starts to go. She felt that when you lost your confidence you were a 'waste of time'. Here, skill and confidence are placed together as parts of a whole.

In spite of the helicopter coming in and gathering up patients to take them to the larger centre, it is not the case that emergency skills are never needed. It is here that some of the tension of maintaining some level of emergency service while working in a downsized environment with less acute patients is manifest. Nurses are concerned about the maintenance of practical skills and knowledge at a level that they are comfortable with.

There are some very real issues here and I am left with a list of questions. How is the maintenance of skills that may only be practiced occasionally to be managed? How much of what the town nurses do is generic to most nurses and how much is specific to these generalists? How are they to maintain their competencies in this conflicting situation? I do not expect that there will be answers to these questions in the short term, but hope that in raising the issues they may at least be debated.

One of the strategies that has been employed by some nurses as a response to the work environment with which they were faced, was to consider either move away from town, or to commute seeking alternative nursing work. The issue of mobility which constitutes a critical theme in the nurse's narratives is explored in the following chapter with particular reference to gender dynamics.

CHAPTER SEVEN

To Move or Not to Move; That is the Question: The Gendered Dynamics of Mobility

As was noted in chapter five, the concept of mobility is one of the features of the contemporary labour force. However Callaghan (1997) argues that mobility of the labour force is actually a manifestation of the rhetoric of flexibility. The flexible notion of expansion and contraction according to labour market need carries the same stamp whether it is focused on increases in part time and casual employment, a shift from specialisation to multiskilling, or "the potential for workers...to shift between declining and expanding industries and occupations" (Callaghan 1997: xiii).

On a macro level, this tendency for workers to move between labour markets can be seen to be functional to the adequate provision of labour. However on a micro level the situation in small towns is rather more complex. Since the hospital 'industry' has not closed, but only downsized, it is not in government or local hospital management's interests if workers (nurses) do become mobile and shift out to expanding industry (city hospitals).

There has been a variety of responses to the unsettled and unsettling nature of the employment situation for nurses in the town. Some nurses have chosen to 'wait and see' what happens next while others have left, and some have to cut down their work load. Many used the latest round of restructuring to think long and hard about just what they wanted. Given the issues that have been raised in chapter six around the issues of job satisfaction and maintenance of skills, it should come as no surprise that most of the nurses interviewed had considered either moving out of town for nursing work in a city, or had considered commuting to the nearest large hospital for work. These nurses had discussed and talked at length with partners and family members about the issues of mobility. Some of the enabling and constraining factors which were identified during these conversations were highlighted in chapter five. These factors included ages of children, attachment to place, age of partner and likelihood of his gaining work elsewhere, financial pressure that would result from a move to a

larger place and so on. Interestingly, not one of the nurses said that they were concerned about their ability to find work elsewhere[53].

Although the enabling and constraining factors on women's mobility for work are not solely confined to the town, the implications are greater in this town location with its limited job market. In the town, the dynamics of mobility for work are obviously very complex and may involve moving a whole family to the city. Whereas, nurses in the city may have the opportunity to change wards, or even hospitals within the same city, if the place of work does not fit closely with the sense of professional identity that the individual holds. Shifting workplace for the city nurse may mean no more than changing the route to work[54].

A desire to move out or commute to alternative nursing work can be seen to be one of the ways in which the professional identity may be placed in the foreground and it is particularly salient to the town location, in terms of the debates about women's commitment to work which were discussed in chapter three. Flexibility and mobility in the contemporary workforce are promoted as desirable traits; however as Jarvis points out, "Rarely does promotion of the 'new labour force' acknowledge the tension that clearly exists between the mobility of individual labour and spatial situatedness of the household" (1999: 243). Therefore what seems to be constructed as a simple mathematical equation, willingness to move for work = high commitment to paid work, is rather, as Hanson and Pratt point out, too limited. They suggest instead that subjectivity and geography are reciprocally constituted. They note that this awareness:

> pushes us beyond considering geography and local labour markets only in terms of opportunities and constraints, as envelopes of resources that allow or disallow individuals to fulfil their preconceived potentials; it opens the recognition that gendered identities, including aspirations and desires, are fully embedded in - and indeed inconceivable apart from - place and that different gender identities are shaped through different places. (1995: 18)

---

[53] This omission may be reflective of the acknowledged shortage of nurses worldwide. This shortage is commented upon occasionally in the media and is also evident in the number of advertisements for nurses in Britain and Australia in the job vacancies sections of the New Zealand press. These overseas jobs often have significant incentives attached to them.

[54] It is not the case that nurses in cities are blissfully happy with their work because they are able to be mobile with more ease. There are many issues that nurses, across the board, are concerned about at present. I do not wish to present mobility as a panacea for all that ails nursing, but rather to highlight the tension of distance and the difficult decisions which face many of these nurses.

The gendered dynamics of mobility

In a non-gendered model of work commitment, it would seem that either a male or a female could make a decision to move for work. However, as many studies (Hanson and Pratt 1995; Bruegel 1996 among others) have shown, mobility, both, in terms of travelling, and moving for work is highly gendered. Duncan, for instance, argues that while people are all located differently in space, "there are radical inequalities in the spatial spread of individual's lives....[Further], it is often the case that it is women who have the most spatially restricted lives" (1996: 31). There are a number of ways in which women's work can be seen to be spatially constrained. Hanson and Pratt, for example, in their study of Worcester (1995), note that women tend to work closer to home than men, and are, thus, more dependent upon local labour markets. Studies carried out in the 70s and early 80s "revealed that women tend to travel less frequently over shorter distances, and via different means of travel than [did] men" (Hanson and Pratt 1995: 8). Bruegel and Pearson found that women's journey's to work had lengthened in the last twenty years, at least in Britain (cited in Bruegel 1996: 251). Locally, the situation would appear to bear this research out. A study carried out on several hundred nurses by the New Zealand Nurses Association found that "nurses mobility is severely limited by family commitments - 71% state their freedom to move to another job outside their present location is 'entirely dependent' on other people" (NZ Nursing Journal. Sept 1992: 15).

Most nurses seek employment in hospitals and are fairly reliant on having access to centres of population. The journey to work to a larger centre for the nurses in this study would typically take from one to one and a half hours one way, thus adding a significant two to three hours on to the eight hour nursing shift for those who sought to commute for work.

Some of those nurses who had thought of commuting for work had come to the conclusion that it would be better to stay in the larger centre overnight rather than travel backwards and forwards every day to work. One nurse had already operated a system such as this for many years although she now worked closer to home. While it is the case that some nurses expressed distaste for driving long distances to work,

many would consider it if the situation deteriorates further at the hospital. However, commuting for work did not present an easy solution. Rather, it presented some of those with children at home with problems which were introduced in chapter five. The problems with commuting were associated mainly with the need for the nurse to spend overnight time away from home. Although for some, Ruth for instance, it is not only the presence of children that puts her off being away overnight regularly for work:

> *Even if my kids weren't here, I still like to not be away.* (Ruth)

For Sarah, the issues are slightly different; although she is willing to think about commuting for work, it is not an uncomplicated prospect since she is a part-time nurse and also has another job. There are clearly limits around what she is willing to take on and she is obviously balancing her options very carefully, taking many factors into consideration:

> *If I did get a job in* [another center] *could I still continue my* [other job], *that was my biggest concern...could I still do both as effectively as what I do now? Would I be more tired, that was the thing, you know, I'm getting older not younger, could I still do it and do it effectively, or would I be jeopardising something, would something go, like my health. I mean we've got to think constantly about being healthy nowadays, approaching those years and you know, having your body tired is not a good thing.* (Sarah)

Sarah also tended towards the opinion that it may be somewhat simpler to move for work rather than to travel, however, moving from the town presents complicated ties and pulls which will be shortly discussed in the context of breadwinning.

Denise is convinced that if she did not have children, then she would be living apart from her partner if he wanted to remain in the town, so that she could return to the hyperskilled field that she previously worked in before moving to the town:

> *If we didn't have children there would be a commuting relationship going on between my husband and myself if he wanted to work here.* (Denise)

Most of the nurses who had thought about commuting had ruled it out at this stage but that did not mean that they were immobilised. Although many factors will influence their decisions (which will probably never be final), the conversation about moving out for work is an open one.

Gendered Breadwinning?

Traditionally, it is not women's paid employment that has been the initiator of mobility for the purposes of work. The reasons for this were often assumed to be located in the domestic sphere where it was assumed the bulk of women's energy would be spent. It has been assumed that the male occupied the role of 'breadwinner'. The male had the main claim to paid work, since in a rational economic model his job must be protected for the economic good of the family. This grounding of decisions regarding who gets to participate in paid work in rational economic terms usually results in men being breadwinners since their incomes are often higher than that of women. Thus any income a woman earned would be seen to be 'secondary' and her commitment to paid work would be assumed less than that of a man.

If a decision to move for work is based on a purely rational economic model such as that suggested above, then the male (who is usually the breadwinner), prompts a move for work in order to protect the income of the family, or to advance his career. As Bielby and Bielby note: "[i]f financial resources provide leverage in bargaining between spouses, then the partner with the greater earning capacity is likely to gain the most in negotiating over whether or not to relocate for a job opportunity in a different location" (1992: 1244). Some of the experiences seem to support this spatial constraint on economic grounds. Of the two people who earned substantially less than their partners, one when asked if she could imagine relocating for her work said:

> *it would be really amazing to think we could move for me, but thinking about the people in this family that's not a good fiscal thing to do....job security is so important once you have children because of their education, their security, all of that has to be taken into account. I don't feel I have the right to be that selfish.* (Denise)

There is an adherence here to the economic rationality model, in spite of great discontent on Denise's part regarding her paid work situation. However, it has also been suggested that rather than being confined to a question of comparative earnings, there is also the question of gender role ideology.

Bielby and Bielby, for instance note that the power of the traditional husband is "indirect and culturally mediated to the extent that his role as provider is taken for

granted and mutually recognized by both spouses" (1992: 1261). Ideologically speaking Denise felt 'more responsible' for the children since, as she said, she bore them. 'Bearing' and 'raising' children may be not be seen as separate activities even though they can, at least potentially, be carried out by different people. Denise highlights the practical difficulty of actually splitting bearing and raising children when she assumes she is 'more responsible'. For her, 'selfishness' would be to expose the family to the possibility of a much lower income because she wanted to engage in paid work that was not available to her locally. Somewhat paradoxically, Denise's 'resistance' in the face of an unsatisfactory situation is to *not* engage in paid work in the town. However, she definitely intends to commute for work in the future. I am reminded here of bell hooks cautionary remark to white feminists against perceiving paid work to be always and absolutely liberating, when in fact to be able to choose not to engage in work, which does little but provide a pay cheque, is itself liberating. This is also a luxury that not all may partake in.

If indeed financial considerations are the ground of decision-making regarding moving for work, then how is that decision made if partner's incomes are not vastly different, or if the woman earns more than the man? This leads to questions surrounding the relative decision-making power which is afforded to different members in a household, in terms of how decision making is attached to the amount of money earned, and the place that gender plays in decisions to move for work. Bruegel notes that "migration behaviour is taken to reflect power relations within the household and the degree of mutuality in decision-making processes" (1996: 236). A lot of the literature on moving for work appears to use the corporate world as its point of reference, whereas the people that are involved in this study are not, in the main, part of the corporate world. The issues here are rather different when both working partners earn roughly equal income. Further, the situation is more complex if it is not clear exactly who is earning more money and whose job is more or less stable or more or less satisfying.

The income levels of the town are relatively lower than those of the general population. For example, in figures taken from the 1996 census, over sixty five

percent of the population of the town earned under $20,000. When this is compared with New Zealand as a whole, where only fifty nine percent of the population earn under $20,000, there are already some gaps emerging between the town and larger job markets. It would seem likely that nurses incomes may actually be closer to the higher (though not the highest) incomes in the town, for full time work. This situation may lead towards the supposition that nurses may have more bargaining power within their households in this setting due to their financial contribution.

The contemporary pattern of male employment has somewhat disrupted the traditional 'breadwinner' model since not all men work and not all men who work are full-time; besides, not all men who work earn enough to support a family - even if this were desirable. Crompton et al. for instance, note a trend towards the decline of single income households in Europe is emerging and suggest that it may signal the decline of the male breadwinner (1996: 13). However, many of the women in this study did not perceive themselves to be main 'breadwinners' even if they earned more than half of the family's income.

Women have entered the workforce in unprecedented numbers in the last twenty years. It could be assumed that traditional patterns may have been altered by this repositioning of women in paid work. However, even though some men's employment has changed as discussed above, women still tend to be clustered in, so called, non-standard employment, which often consists of lower paid, part time and temporary positions. Standard employment is considered to be full-time, permanent paid work. So, as Bruegel notes: "the breadwinner model may have been modified, rather than transcended" (1996: 252). Further, Hendershott, using the work of Hochschild (1989), suggests that:

> the set of ideas a person has about gender are often fractured and incoherent.... There are contradictions between what a person said they believed about marital roles, and what they seemed to feel about them.....[hence] the male provider role continues to be a symbolic construct that provides one with a readily available model about what is acceptable. (Hendershott 1995: 165)

Towns and rural areas have often been assumed to be conservative places with 'old fashioned' attitudes. This assumption could lead to the supposition that gender relations were and are conservative. Yet, of those nurses whose incomes were much closer to those earned by their partners, or in some cases were greater, several had actually talked about moving specifically for the nurses' work. This is seen as a rather non traditional set of negotiations. According to Hendershott:

> moving for the wife's job advancement is not among the choices considered when couples with traditional gender roles beliefs negotiate role behaviours and responsibilities. These couples would just not consider moving for a wife's work. (Hendershott 1995: 164)

Considering relocating for the sake of paid nursing work can be seen as a way of indicating commitment to work. However, the fact that many of the nurses work part time can raise questions about work commitment which will be discussed shortly. In a sense part-time work and commitment to work seem to work against each other, in that Jarvis found that 'flexible' households (usually a male in full time employment and a female in part time employment) are "a particularly enduring structure type, strongly associated with inertia" (1999: 239). She goes on to say that it is not the "presence of a second earner which impinges on mobility, *per se,* rather that the presence of a second earner forms part of a strategy of non-mobility. This strategy reflects a strong attachment to local kin and social networks" (Jarvis 1999: 239).

Ties to the Town

As was indicated in chapter five, nurse's attachment or ties to the town were often contradictory, however, Jarvis notes that "it is rootedness within socially and spatially constituted systems of support which directly influence household mobility strategies" (1999: 242). It seems though, that "kin and social networks" are not fixed and may in fact shift over time, particularly in the rural/town setting. Children grow up and leave to either seek jobs in larger centres or to participate in tertiary education or training. Given that many of the nurses are into their forties and older, many of their parents have died and some will not be living in the town anyway since some of the nurses came to the town on marriage. Friends are perhaps a little more constant than family,

however, given the unstable nature of local work, many have moved on to larger centres. As Lucy says:

> *In the last year I've had a mass exodus of all my friends in their different professional jobs who have moved on. My last close friend is ready to leave here very shortly....It's come a time, none of our children live here any more.* (Lucy)

Sarah's perception of her ties is quite clear:

> *I've got nothing, we've got no ties apart from* [the other job that Sarah does], *and I could start that up again* [somewhere else]. (Sarah)

Kin and social networks may not be the tie that they have been perceived to be in towns and rural areas in the past. Given the major waves of restructuring that have occurred over the last fifteen years it seems inevitable that the networks in towns would be affected and that people would begin to 'look out' for themselves more than may have been the case in a more stable economic climate nationally and internationally. However, in spite of the need to 'look out' for oneself and the increasing individualism that seems to be part of our age, there is often the issue of children to take into account in decision making regarding moving for work.

Children and Mobility

More attention appears to be paid in the literature to the constraint of the partners job, whereas it would seem that a bigger issue for at least some of these nurses was their children. Of those nurses who still had children at home, the situation of the children was of great importance in decisions about moving for work:

> *how would they adapt if you shift....they're doing ok at school....* (Patricia)
>
> *We've thought of moving, but then again there's the kids...it's unsettling for them too.* (Ruth)

But then, having thought about moving for some time now, some of the children have started to rethink their original negative attitude towards a move:

> *You know, I thought they were dead against us moving. they have made noises of late that they wouldn't mind moving.* (Ruth)

As for Denise mentioned previously, both Ruth and Patricia are concerned about the stability and security of life for their children. However, it is again an unfixed point of

concern that in the small town setting it is usually the case that young people leave town to work, train, or study. It is, in a sense a rite of passage for young people from towns to leave home when they leave school. If parents choose to relocate, then this rite of passage may become meaningless, and parental relocation may actually be resisted as it was in the case of Patricia's teenager when the question of the parents relocating was bought up:

> *she's already in that rural setting of, "when I leave to do whatever I want to do, I am leaving home then...I don't want you guys in the same town thank you".* (Patricia)

However, in the sense that a parent often, if not usually, assumes responsibility for making decisions that do not unduly negatively affect their child or children, they in the last instance must make the decision to relocate or not.

Another factor for a number of nurses was the age of their partner and their concern about his ability to find work elsewhere. It is well documented by now, even in the popular media, that people's chances of getting jobs as they get older are diminishing. Some partners had 'portable' occupations but others would be competing for what they could get. Hence, in summary, for many women life stages matter, including numbers of children elderly parents[55] and age of partners. The 'ages and stages' of the nurses seemed to have an impact on how they had worked through mobility issues. While acknowledging the importance of life stages in women's working lives, Walby notes that care needs to be taken in using labour market and industrial structures to explain patterns in men's work, and domestic structures to explain patterns in women's work (Walby 1997: 120). Rather, the web within which nurses patterns of paid working are negotiated encompasses both "labour market and industrial structures" and domestic ones. Further, Bielby notes: "most empirical work over the last three decades has focussed on work commitment, as if commitment to family, in contrast, was a natural and unproblematic outcome of household arrangements" (Bielby 1992: 289).

[55] In spite of increasing attention being paid to the issue of an aging population and the increased care needs which come as a result of that, none of the nurses indicated that they had assumed responsibility for the care of aging relatives.

Women's attachment to Work

In the model of 'work' that prevails (often in spite of evidence to the contrary), paid work is assumed to be the central source of identity, thus women's willingness to move for their work would seem to be a gauge of their desire to protect this identity. As Bielby notes, commitment to work:

> is seen as an attachment that is initiated and sustained by the extent to which an individual's identification with a role, behaviour, value, or institution is considered to be central among alternatives as a source of identity....Centrality of identity implies that it is particularly significant, meaningful, or salient within an individual's personal hierarchy of identities or self-meanings. (Bielby 1992: 284)

As has already been shown, women's mobility is traditionally more limited than that of men. It should come as no surprise that the situation is vastly more complex than simply to relocate if you have a high commitment to paid nursing work. Jarvis (1999) calls the multitude of networks which interact to provide the context for mobility for work decisions "the tangled webs we weave"; indeed they are tangled, 'embedded' even. The actions people take under unsatisfactory paid work conditions are embedded in, and are highly contingent upon a raft of enabling and constraining factors which cannot be separated out from a professional identity.

The ways that commitment to work has traditionally judged are often such things as numbers of hours worked (part time or full time) and continuity of employment. For instance; Hantrais (1990) found, when comparing the place of women in the education systems in both Britain and France that "French women....demonstrate a greater degree of attachment to a career by more often pursuing an uninterrupted work history" (1990: 175). Here an uninterrupted work history is equated with attachment to work. French women tend to engage mainly in full time work when they engage in paid work (Dex et al. 1993), therefore continuity is probably continuous full time work in this sense.

Peoples' work histories are becoming more and more 'interrupted' in the sense that there is much more mobility between jobs. This movement is considered to be an 'acceptable interruption', while an interruption in order to bear and or spend some

time raising children is not. This reinforces the problematic nature of caring work, both paid and unpaid, which seems to rely on an assumption of 'natural' abilities or tendencies.

In spite of the assumption that full time working indicates commitment and continuity to work, Ruth for instance, considers that there is a continuity about her work in spite of the fact that over her working life of about twenty two years some of her nursing work has been part time and some full time. Continuity, thus, seems to play a part in Ruth's perception of what nursing work means in her life and her commitment to it, even though that may not fit with a mainstream analysis of her participation in paid work:

> *it's been all my working life really, I've never really stopped nursing....When I think about it, it plays a big part in my life, a very big part...* (Ruth)

Sarah who had not worked full time in nursing since she qualified in the mid 70s, was seriously considering a move for work (surely a marker of commitment?). Rose, as well, insists that work is *very* important to her:

> *it's part of my life, and even if I won Lotto I would need to do a couple of days.* (Rose)

For Annabelle, nursing provides another source of identification apart from the role of 'mother':

> *I really don't like being an at-home Mum....It's quite good to be Annabelle the nurse, you know, rather than Mum.* (Annabelle)

For these women full time nursing does not appear to be a necessary part of their claim to a paid work identity. This begs the question as to whether their decision-making is reflective of an accommodation which is made as a result of circumstances that they find themselves in. Is it the case that these nurses have merely been socialised into a 'secondary' place in the job market? This can only be argued to be the case if the so-called 'male' model (full time and unencumbered) of work is accepted as the norm.

Bielby advises caution in arguing that the work practices that are engaged in equate with/to a greater or lesser attachment to paid work. She notes:

> in operationalizing the identity definition [of commitment], analysts typically assume individuals are fully cognizant of what is meaningful to them, are

> unencumbered by situational constraints or opportunities, and have the latitude to behave in a manner that corresponds with their identity. (1992: 285)

Men, in general, are more often perceived to fit the ideal model above, (though they are not perfectly aware), unencumbered and free to 'behave in a manner that corresponds with their identity. In the town setting, as we saw in chapter five, the unstable nature of the local job market alone provides a context in which many people, both men and women, are 'encumbered' and may be unable to 'behave in a manner that corresponds with their identity' in terms of work.

To conclude, and following Jarvis, it seems to be evident that:

> Whether a household moves or stays in a particular housing and labour market context is as much influenced by 'social', non-material, as by economic motives....[E]conomic accounts do not adequately explain the process or framework of their day-to-day decisions" (1999: 242).

Mobility decisions are made tentatively and are open, in many cases, to review later should circumstances change. Rather than seeing the nurses in this study as immobilised, it is important to take account of the 'tangled webs' in their lives and times as illustrated in the course of this chapter. The issue is not just a question of whether nurses are willing and able to commute or relocate for work, but rather how their gendered professional identities are inflected and played out *in place*. Indeed, the issue is also how places and local economies constitute nurse's subjectivities. As Hanson and Pratt conclude, "the meanings and impacts of distance are not only place-contingent and socially constituted; because individuals are constrained by space, different ways of life develop in different places" (1995: 10).

CONCLUSION

Writing a conclusion is somewhat strange in this moment when all seems so open, explored and 'in process', with so much more that could be said. However, conventionally there is a need to make some concluding statements.

The existing body of literature is rather inadequate to the task of explicating the specificity of context in which Registered Nurses negotiate the process of restructuring in towns. I have attempted to provide a contextualisation of the reconstruction of the professional identity of registered nurses in a New Zealand town. The aim of this exploration has been, partly, to address the marginalisation that both towns and nurses experience in this climate of restructuring. That is not to say that the picture presented here is comprehensive and all-encompassing, this would be too ambitious and doomed to fail, since I believe that we are never completely aware of all the discourses around and through which people negotiate ways of being.

My hope is that over the course of this study it has become clear that place, the previously neglected parameter (Foucault 1986; Soja 1989, among others), matters in the lives of people. Space matters, most specifically in the lives of town nurses, in the construction, negotiation and maintenance of a professional identity. Nurses are marginalised within the health professions generally, and also within the health system. Towns are marginalised in the hierarchy of space where the urban is the privileged site. Within the health system, town hospital services are deemed peripheral to the specialist and high technology city hospital. Therefore, an understanding of the spatially differential effects of restructuring highlights the ways in which the situation of nurses in towns differs from that of nurses in cities. Furthermore, in the sense that place/space is differentially affected by processes of restructuring, it is clear that space is not inert and fixed, but rather, the notion of space encompasses not just physical, but also social and political dimensions.

In chapter two and three the issues of how the contemporary professional identity of nurses is negotiated against an historical background of nursing as a vocation and as 'women's work' is explored. The association of nursing with the concept of care (which is devalued generally) is problematic in that it can be in conflict with the notion of 'profession'. Nursing has followed the route of credentialism in order to consolidate its claims to professional status. However credentialism, with its focus on academic and technical skill can serve to marginalise the care component of nursing work. Thus, contemporary nursing is often judged by its most technical areas. The most technical areas of nursing are also the most specialised.

Most important to this thesis, is the way in which nurse's professional identity has been redefined as less specialised in the process of health restructuring in the town. Downsizing, including loss of surgical services, has created a need for members of nursing staff to fill a variety of roles and cover a wide range of patients. Thus, the mobilisation of the notion of flexibility, both by management and nurses remains crucial in the labour market debate. Numerical flexibility is widely practiced in most hospitals, thus is not a characteristic of only town hospitals. However, flexibility, enacted as multiskilling is more characteristic of restructured town health services. Multiskilling moves town nurses further away from the most privileged (specialised) parts of nursing (those more closely associated with high technology) and thus has the potential to place them in a more marginal position professionally. Multiskilling, although not automatically a negative concept, presents certain problematic issues for nurses. The construction and maintenance of a multiskilled or generalist professional status is a complex issue to be discussed and negotiated, rather than a status automatically produced by a new management definition of what it requires of nurses.

Although at first glance this reconstruction of professional identity can be argued to have been imposed upon nurses by managers, it is important to remember Foucault's conceptualisation of power as "not something that is acquired, seized, or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the interplay of nonegalitarian and mobile relations" (1990:

94). In this sense then, 'power' is a more complex entity, a more free floating and contested force. So while the power exercised by management in 'imposing' conditions on the nurses can be seen to be coercive and open to the assumption that it is a unilateral initiative, nurses in this study also exercised power (and in fact had the potential to exercise coercive power by withdrawing labour). The fact that most did not do this does not mean that nurses exercised no agency. But as Knights points out:

> Whether or not technologies of power ... are resisted depends upon the extent to which they confirm or threaten prevailing subjectivites. That the result, especially within the labour process, is so often conformity, compliance or a resigned indifference is partly because of the difficulty in mobilizing collective resistance among individualized subjects (Knights 1987:32).

Another facet of flexibility; mobility, is considered to be a critical issue in this thesis. Mobility is seen to be one of the hallmark characteristics of the contemporary labour force. In fact as Callaghan (1997) pointed out, mobility is part of a rhetoric of flexibility, in which expansion and contraction according to management need are the major features. However, in the setting of the town the usual ways that mobility is expected to be deployed are turned on their heads. Ordinarily, mobility in the context of labour means the willingness of workers to move from areas which are contracting to those which are expanding. This construction is another example of the 'more market' policies of restructuring in operation. However, it is not in the interests of local hospital management for the nurses to leave town for the expanding job market in the city.

Commitment or attachment to paid work has often been judged by a willingness to relocate for the purposes of work. Women have more often been perceived as "trailing wives" (Bruegel 1996) than initiators of mobility themselves. In a town environment in which few people are untouched by the process of restructuring, nurses seem to be very willing to contemplate relocating or commuting for their work. However, the bind that nurses found themselves in when they explored the enabling and constraining factors, the weighing up of which made or halted mobility decisions, was rather complex.

The very fact that nurses were seriously considering relocating or commuting for alternative nursing work does, I think, represent a significant departure from the passive wife who followed a husband for his work. Even if the majority of nurses remain in the town, they do not do so for unexamined reasons. Meeting the employment needs of more than one person in a family is inevitably difficult as conflicts of interest can and do arise between partners (see Bruegel 1996; Hendershott 1995; Bielby and Bielby 1992 amongst many others). However, most of the nurses have attempted to balance the social, emotional and economic costs of relocating to both themselves and their household members. Here again space matters, in that relocating from town to city is an expensive undertaking in social, economic and emotional terms.

The process that nurses enter into when making decisions regarding mobility challenges the assumption that a professional identity is to be privileged to the exclusion of other competing identities. However, we are left with a conundrum since an economic identity remains the one which is socially recognised and desired by many, if not most, people (see Else 1992). Furthermore the economic identity that is valorised is one which has at its centre a full time unencumbered worker, an identity which a minority of nurses bring to work. The valorisation of an economic identity only serves to reduce the person (in this case the nurse) to their profession. A view that I think is somewhat limited and limiting, since it reinforces the very argument that has been employed to marginalise work not carried out in the public sphere.

This complex situation highlights the great distance that is yet to be travelled in exploring the issue of women, men, children and work, as well as the issues of towns and rural settings. Furthermore, restructuring is not a finished product but is rather an on-going series of minor and major rounds of reform. Each round requiring a re-negotiation of spatialised identities, powers and practices.

It is not possible to say at this point in time that since most of the nurses have elected to stay on (thus maintaining the status quo) that they are immobile permanently. At this stage nursing contracts are renegotiated annually with management. Thus it is

likely that the process of reassessment and re-evaluation, regarding the place that town nurses are willing to occupy and how that is to be negotiated, will be ongoing.

Recommendations

The negotiation of the competing discourses through which nurses must make sense of their ways of working means balancing their professional standards for practice and skill maintenance, with a work environment which makes multiple demands on their skills and training. It would, I believe, be very helpful to town nurses if the changed situation were acknowledged and consultation begun in order to provide a structure of ongoing education to meet the learning needs of nurses in this multiskilled environment.

It seems that a consultative process could reasonably expect to be entered into between nursing staff and management with respect to the learning needs of town nurses. The range of areas in which they need to be able to demonstrate competence is broad and may be able to be delivered as a package. Thus, perhaps a more specifically targeted type of professional development and ongoing education may be required for nurses working in the town setting[56]. This may enable the development or reinforcement of a discrete professional identity, which has many similarities with nurses everywhere, but also maintains some specific identifying features, of the generalist environment in which town nurses work.

Areas for further study

One of the major areas that it seems important to point to as an area of future study is that of the possible effects of increasingly generalised registered nursing work in towns. It is possible that at some point it may be suggested that these more general types of registered nursing work could be carried out by lesser trained health care staff. With the reintroduction of Enrolled Nursing it would seem likely that there may

[56] The need for a specifically targeted program for rural practice nurses was identified and there is currently a program running from Christchurch which attends to this perceived gap in education for a specific setting. This program acknowledges the expanded role carried out by 'rural' as opposed to 'urban' practice nurses and tailors education specific to their learning needs.

be some shift in employment practices and requirements, as Enrolled Nurses are cheaper to pay. The other area which would reward further work would be a larger study of both rural/town and urban nurses in the context of the reform process. A larger comparative study would show in more detail the ways in which space/place makes a difference to the professional practice of Registered Nurses. Furthermore, as Competence Based Practicing Certificates are introduced, the process by which both urban and non-urban nurses seek to meet the requirements could be followed.

THE RESEARCH PROCESS

The process of doing research with 'real people' as opposed to literature only, presents the researcher with some challenges. One of the most problematic for me was the interpretation of the data gained from the interviews. While expecting themes to 'emerge' from the data that were core issues for the nurses I was aware that the process of gathering was always already influenced by the researcher (myself), particularly by the questions that are asked during the interviews. It seems that it is only possible to leave things 'open ended' up to a point. By the time I as a researcher had carried out background reading prior to interviewing the participants in this research I had a substantial positioning within the body of literature. Thus I consciously focused on mobility and the downsizing and loss of surgical services that has intensified multiskilling.

Inevitably this focus may not be the one that any or all of the research participants deemed most important. However, I do not believe that it is possible for a researcher to perform as a blank slate upon which the 'truths' of registered nurses experience may be inscribed. This process of thought made me all the more aware of the notion of positioning as mentioned in chapter four. However, in saying the above, I hope that what I have presented in this research is in some way explores issues that the interviewees deemed to be important to them.

It became obvious during the course of this research that some groups were, in effect, missed out, most particularly those nurses who work in the community that I interviewed. During the course of writing up of this thesis, the focus shifted to be upon registered nurses who worked in the hospital setting since I felt that it was their situation which had changed to a more major degree in terms of work tasks. However, in terms of pay and conditions all of those nurses who were employed by the local health authority were affected, including those who worked in the community. However, in the final analysis, I felt that groups such as district nurses would be better served by a study devoted to them alone - rather than having their work situation

collapsed in with hospital nurses. Any comments on this point (or any others for that matter) would be appreciated however.

ACKNOWLEDGMENTS

I would like to thank, first of all, the staff of the feminist studies department at Canterbury University. I have taken courses with all of them and hence they have contributed to my knowledge base from which this thesis took shape. Particular thanks goes to Dr Nabila Jaber for her supervision and guidance of this piece of work.

My fellow postgraduate students have been friends, sanity savers and partners in academic conversation. The process of thesis writing would be a lonely one indeed if it were not for the presence of others engaged in similar undertakings. Rowan, Ruth, Naomi, Jo, and Michael, thank you all. Thanks also to John who has been supportive and encouraging throughout my postgraduate work.

This thesis would not have been possible without the willing contribution of the fourteen nurses who were interviewed. I am deeply grateful to them for agreeing to participate and giving of their precious off-duty time.

REFERENCES

Abbott, Pamela, and Claire Wallace. 1990. Social Work and Nursing: A History. In *The Sociology Of The Caring Professions The Sociology Of The Caring Professions,* eds. Pamela Abbott and Claire Wallace. London: Falmer Press.

Acker, Joan. 1990. Hierarchies, Jobs, Bodies: A Theory of Gendered Organizations. *Gender and Society* 4, no. 2 (June) : 139-158

Alldred, Pam. 1998. Ethnography and Discourse Analysis: Dilemmas in Representing the Voices of Children. In *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives,* eds. Jane Ribbens and Rosalind Edwards. London: Sage.

Ansley, Bruce. 1999. The Future of Work. *The New Zealand Listener,* 4 September: 14-19.

Arber, Sarah, and Jay Ginn. 1995. The Mirage of Gender Equality: Occupational Success in the Labour Market and within Marriage. *BJS* 46, no. 1 (March) : 21-43.

Armstrong, Nicola. 1992. Handling the Hydra: Feminist Analyses of the State. In *Feminist Voices: Women's Studies Texts for Aotearoa/New Zealand,* eds. Rosemary Du Plessis, P. Bunkle, K. Irwin, A. Laurie, and S. Middleton. Oxford University Press: Auckland

Armstrong, Nicola and Rosemary Du Plessis. 1998. Shifting Certainties, Complex Practices: Reflections on Feminist Research. In *Feminist Thought in Aotearoa New Zealand: Connections and Differences,* eds. Rosemary Du Plessis and Lynne Alice. Auckland: Oxford University Press.

Ashton, T. 1999. The Health Reforms: To Market and Back? In *Redesigning the Welfare State in New Zealand,* eds. Jonathan Boston, Paul Dalziel and Susan St John. Auckland: Oxford University Press.

Atkinson, John, and Nigel Meager. 1986. Is flexibility just a flash in the pan? *Personnel Management.* (September) : 26-29.

Attewell, Paul. 1987. The Deskilling Controversy. *Work and Occupations* 14. no. 3 (August) : 323-346.

Badgett, M.V. Lee, and Nancy Folbre. 1999. Assigning Care: Gender Norms and Economic Outcomes. *International Labour Review* 138, no. 3 : 311 - 326.

Barnett, J. Ross. 1999. Hollowing out the State? Some Observations on the Restructuring of Hospital services in New Zealand. *Area 31, no.2 : 1-12.*

Barnett, Pauline, and J. Ross Barnett. 1999. Reform and Change in Health Service Provision. In *Health and Society in Aotearoa New Zealand,* eds. Peter Davis and Kevin Dew. Auckland: Oxford University Press.

Barwell, Ismay. 1994. Towards a Defence of Objectivity. In *Knowing the Difference: Feminist Perspectives in Epistemology,* eds. Kathleen Lennon and Margaret Whitford. London: Routledge.

Bhabha, H. 1994. *The Location of Culture.* New York: Routledge.

Bielby, D. D. 1992. Commitment to Work and Family. *Annual Review of Sociology* 18, : 281 - 302.

Bielby, W., and D. Bielby. 1992. I Will Follow Him: Family Ties, Gender-role Beliefs, and Reluctance to Relocate For a Better Job. *American Sociological Review* 97, : 1241 - 1267

Blank, R. 1994. *New Zealand Health Policy: A Comparative Study.* Auckland: Oxford University Press.

Boschma, Geertje. 1997. Ambivalence about nursing's expertise: the role of a gendered holistic ideology in nursing, 1890-1990. In *Nursing History and the Politics of Welfare,* eds. Anne Marie Rafferty, Jane Robinson and Ruth Elkan. London: Routledge

Boston, J. Dalziel, P., and Susan St John. 1999. *Redesigning the Welfare State in New Zealand: Problems, Policies and Prospects.* Auckland: Oxford University Press.

Bradley, Harriet. 1999. *Gender and Power in the Workplace.* London: Macmillan Press.

Braverman, H. 1974. *Labour and Monopoly Capital.* New York: Monthly Review Press.

Britton, S., R. Le Heron, and E. Pawson. 1992. *Changing Places in New Zealand: A Geography of Restructuring.* Christchurch: New Zealand Geographical Society.

Brodie, Janine. 1996. New State Forms, New Political Spaces. In *States Against Markets: The Limits of Globalization,* eds. Robert Boyer and Daniel Drache. London: Routledge.

Bruegel, I. 1996. The Trailing Wife: A Declining Breed? In *Changing Forms of Employment: Organisations, Skills and Gender,* eds. Rosemary Crompton, Duncan Gallie, and K. Purcell. London: Routledge.

Butler, Judith. 1992. Contingent Foundations: Feminism and the Question of 'Postmodernism'. In *Feminists Theorize the Political,* eds. Judith Butler and Joan W. Scott. New York: Routledge.

Callaghan, G. 1997. *Flexibility, Mobility and the Labour Market.* Aldershot: Ashgate.

Christopherson, S. 1989. Flexibility in the US service economy and the emerging spatial division of labour. *Transactions of the Institute of British Geographers* 14, : 131-143.

Conradson, D., and E. Pawson. 1997. Reworking the Geography of the Long Boom: the Small Town Experience of Restructuring in Reefton, New Zealand. *Environment and Planning A..* : 1381-1397.

Coser, Rose Laub. 1991. *In Defense of Modernity: Role Complexity and Individual Autonomy.* Stanford: Stanford University Press.

Crews, J.D. 1972. Problems of a return. *New Zealand Nursing Journal: Kai Tiaki,* (May) : 21

Crompton, R., Duncan Gallie, and K. Purcell. 1996. *Changing Forms of Employment: Organisations, Skills and Gender.* Routledge: London.

Crompton, Rosemary, and Gareth Jones. 1984. *White Collar Proletariat: Deskilling and Gender in Clerical Work.* London: Macmillian Press.

Coopers and Lybrand. 1997. *Health Centres Project,* Published by the Central RHA, Wellington, New Zealand .

Dalziel, P. and J. Boston. 1992. *The Decent Society? Essays in Response to National's Economic and Social Policies.* Auckland: Oxford University Press.

Dalziel, P., and R. Lattimore. 1996. *The New Zealand Macroeconomy: A Briefing on the Reforms.* U.K: Oxford University Press.

Dastmalchian, Ali. 1991. Workplace Flexibility in Professional Organizations: A Study of Canadian Hospitals. In *A Flexible Future? Prospects for Employment and Organization,* eds. Paul Blyton and Jonathan Morris. Berlin: Walter de Gruyter.

Davidson, Carl and Marianne Bray. 1994. *Women and Part Time Work in New Zealand.* Wellington N.Z.: New Zealand Institute for Social Research and Development.

Davies, Celia. 1992. Gender and Management in Nursing. In) *Gender and Bureaucracy,* eds. Mike Savage and Anne Witz. Oxford: Blackwell.

1995. *Gender and the Professional Predicament in Nursing.* Buckingham: Open University Press.

DeVault, Marjorie.L. 1999. *Liberating Method: Feminism and Social Research.* Philadelphia: Temple University Press.

Dex, Shirley, Patricia Walters, and David M. Alden. 1993. *British and French Mothers at Work.* Britain: Macmillan Press.

Davies, Celia. 1995. *Gender and the Professional Predicament in Nursing.* Buckingham: Open University Press.

Duncan, N., ed. 1996. *BodySpace: Destabilizing Geographies of Gender and Sexuality.* Routledge: London.

Easton, B. 1997. The Health Reforms. In *The Commercialisation of New Zealand.* Auckland: Auckland University Press.

Else, Anne. 1992. Gender and the New Right. In *Feminist Voices: Women's Studies Texts for Aotearoa/New Zealand,* eds. Rosemary Du Plessis, Phillida Bunkle, Kathie Irwin, Alison Laurie and Sue Middleton. Auckland: Oxford University Press.

English, B. 1998. *Hospital Services Plan: Securing better hospital services into the future.* Wellington: New Zealand Ministry of Health.

Exworthy, Mark, and Susan Halford, eds. 1999. *Professionals and the New Managerialism in the Public Sector.* Buckingham: Open University Press.

Folbre, Nancy. 1994. *Who Pays for the Kids? Gender and the Structures of Constraint.* London: Routledge

Form, William. 1987. On the Degradation of Skills. *Annual Review of Sociology,* 13 : 29-37.

Foucault, Michel. 1986. Of Other Spaces. *Diacritics* (Spring) : 22-7.

Foucault, Michel. 1990. *The History of Sexuality Volume One: An Introduction.* New York: Vintage.

Fougere, Geoff. 1995. What is the Core Business of Vote: Health? Paper presented to Symposium on the Delivery of Health Services to Smaller Communities. Co-sponsored by: The National Advisory Committee on Core Health and Disability Support Services; Regional Health Authorities; Auckland Institute of Technology; Auckland School of Medicine.

Fraser, N and L. Nicholson. 1990. Social Criticism without Philosophy: An Encounter Between Feminism and Postmodernism. In *Feminism/Postmodernism,* ed. L. Nicholoson. New York: Routledge.

Gallie, D. 1996. Skill, Gender and the Quality of Employment. In *Changing Forms of Employment: Organisations, Skills and Gender,* eds. Rosemary Crompton, Duncan Gallie, and K. Purcell. London: Routledge.

Ginn, Jay. Sara Arber, Julia Brannen, Angela Dale, Shirley Dex, Peter Elias, Peter Moss, Jan Pahl, Ceridwen Roberts and Jill Rubery. 1996. Feminist Fallacies: A Reply to Hakim on Women's Employment. *British Journal of Sociology* 7, no. 1 (March) : 167 - 188.

Godden, Judith. 1997. 'For the benefit of mankind': Nightingale's legacy and hours of work in Australian nursing, 1868-1939. In *Nursing History and the Politics of Welfare,* eds. Anne Marie Rafferty, Jane Robinson and Ruth Elkan. London: Routledge.

Hakim, Catherine, 1995. Five Feminist Myths About Women's Employment. *British Journal of Sociology* 46, no. 3 : 429 -55.

Hakim, Catherine. 1996. The Sexual Division of Labour and Women's Heterogeneity. *British Journal of Sociology* 47, no. 1 (March) : 178 - 188.

Hakim, Catherine. 1997. A Sociological Perspective on Part-Time Work. In *Between Equalization and Marginalization: Women Working Part-Time in Europe and the United States of America,* eds. Hans-Peter Blossfeld and Catherine Hakim. New York: Oxford University Press.

Halford, Susan and Mike Savage. 1995. Restructuring Organisations, Changing People: Gender and Restructuring in Banking and Local Government. *Work, Employment and Society* 9, no. 1 : 97-122.

Halford, S, Mike Savage and Anne Witz, eds. 1997. *Gender, Careers and Organisations: Current Developments in Banking, Nursing and Local Government.* London: Macmillan.

Hanson, S., and G. Pratt. 1995. *Gender, Work and Space.* London: Routledge.

Hantrais, Linda. 1990. *Managing Professional and Family Life: A Comparative Study of British and French Women.* Vermont: Dartmouth Publishing.

Haraway, Donna. 1988. Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies* 14, no. 3 : 575-599.

Harding, Sandra. 1986. *The Science Question in Feminism.* Milton Keynes: Open University Press.

Harding, Sandra. 1987. Introduction: Is there a Feminist Method? In *Feminism and Methodology*, ed. Sandra Harding. Indiana: Open University Press.

Harding, Sandra and Merrill B. Hintikka. 1983. Introduction. In *Discovering Reality: Feminist Perspectives on Epistemology, Metaphysics, Methodology, and Philosophy of Science,* eds. Sandra Harding and Merrill Hintikka. Dordrecht: Reidel Publishing Company.

Hartsock, Nancy. 1987. The Feminist Standpoint: Developing the Ground for a Specifically Feminist Historical Materialism. In *Feminism and Methodology*, ed. Sandra Harding. Indiana: Open University Press.

Hazeldine, T. 1998. *Taking New Zealand Seriously: The Economics of Decency.* Auckland: Harper Collins Publishers.

Hendershott, A. 1995. *Moving for Work: The Sociology of Relocating in the 1990's.* U.S: University Press of America.

Hochschild, Arlie, R. 1983. *The Managed Heart: Commercialization of Human Feeling.* London: University of California Press.

hooks, bell. 1984. *Feminist Theory: From Margin to Center.* Boston: South End Press.

Jarvis, Helen. 1999. The Tangled Webs we Weave: Household Strategies to Co-ordinate Home and Work. *Work, Employment and Society* 13, no. 2: 225-247.

Jaworski, Adam, and Nikolas Coupland eds. 1999. *The Discourse Reader.* London: Routledge.

Johnson, Terry. 1995 Institutionalization of Expertise. In *Health Professions and the State in Europe,* eds. Terry Johnson, Jerry Larkin and Mike Saks. London: Routledge.

Jolley, Moya and Gosia Brykczynska eds. 1993. *Nursing: Its Hidden Agendas.* London: E. Arnold.

Kearns, Robin and Alun Joseph. 1997. Restructuring Health and Rural Communities in New Zealand. *Progress in Human Geography* 21, no. 1: 18-32.

Kelsey, J. 1993. *Rolling Back the State: Privatisation of Power in Aotearoa/New Zealand.* Wellington: Bridget Williams Books.

Kelsey, J. 1997. *The New Zealand Experiment: A World Model for Structural Adjustment.* Auckland: Auckland University press with Bridget Williams Books.

Knights, D. 1987. Subjectivity and the Labour Process. In *Labour Process Theory,* eds. D Knights and H. Willmott. London: Macmillan

Kobayashi, A., ed. 1994. *Women, Work and Place.* McGill-Queens University Press: Montreal & Kingston.

Larner, Wendy. 1998a. Sociologies of Neo-Liberalism: Theorising the 'New Zealand Experiment'. *Sites* 36, (Autumn): 5-21.

_____1998b. The Discourse of Restructuring: Employment in the New Zealand Telecommunications Industry. *Journal of Sociology* 34, no. 3 (November): 264-280.

_____1998c. *Post-Welfare State Governance: The Code of Social and Family Responsibility.* Unpublished paper delivered during Feminist Scholarship Series at University of Canterbury. September 25.

_____1997. The Legacy of the Social: Market Governance and the Consumer. *Economy and Society* 26, no. 3 (August): 373-399.

Lash, Scott and John Urry. 1994. *Economies of Signs and Space.* London: Sage.

Latimer, J. 1995. The Nursing Process Re-examined: diffusion or translation? *Journal of Advanced Nursing,* no. 22 : 213-220.

Le Heron, R and E. Pawson, eds. 1996. *Changing Places: New Zealand in the Nineties.* Auckland: Longman Paul.

Lennon, Kathleen and Margaret Whitford. 1994. Introduction. In *Knowing the Difference: Feminist Perspectives in Epistemology*, Kathleen Lennon and Margaret Whitford eds. London: Routledge.

Lewis, Alan. 1995. The deskilling thesis revisited: on Peter Armstrong's defence of Braverman. In *Sociological Review*. Oxford: Blackwell Publishers.

Longino, Helen. 1990. *Science as Social Knowledge: Values and Objectivity in Scientific Inquiry*. Princeton: Princeton University Press.

Lundy, M. Catherine. 1996. Nursing Beyond Fordism. *Employee Responsibilities and Rights Journal* 9, no. 2: 163-171.

Mackay, Lesley. 1990. Nursing: Just Another Job?. In *The Sociology Of The Caring Professions*, eds. Pamela Abbott and Claire Wallace. London: Falmer Press.

Massey, D. 1984. *Spatial Divisions of Labour: Social Structures and the Geography of Production*. London: Macmillan.

Massey, D. 1994. *Space, place and gender*. Cambridge: Polity Press.

Mauthner, Natasha and Andrea Doucet. 1998. Reflections on a Voice-centred Relational Method: Analysing Maternal and Domestic Voices. In *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives*, eds. Jane Ribbens and Rosalind Edwards. London: Sage Publications.

McDowell, L. 1991. Life without father and Ford: the new gender order of post-Fordism. *Transactions of the Institute of British Geographers*. N.S. 16, no. 4 : 400-19

_____ 1996. Spatializing Feminism: Geographic Perspectives. In *BodySpace*, ed. Nancy Duncan. London: Routledge.

Miller, R. 1972. Role and Status. *New Zealand Nursing Journal: Kai Tiaki*, February : 25-26.

Monk, Timothy and Simon Folkard. 1992. *Making Shiftwork Tolerable*. London: Taylor and Francis.

New Zealand Nursing Journal: Kai Tiaki. 1992. September : 15.

New Zealand Nurses Organisation. 1995. *The Inside Story of the Health "Reforms": A Report of Interviews with Nurses. Wellington: NZNO.*

Nursing Council of New Zealand. 1999. *Guidelines for Competence Based Practising Certificates for Registered Nurses*, April.

Oakely, Ann. 1981. Interviewing Women: a Contradiction in Terms. In *Doing Feminist Research*, ed. H. Roberts. London: Routledge and Kegan Paul.

Patai, Daphne. 1991 U.S. Academics and Third World Women: Is Ethical Research Possible? In *Women's Words: The Feminist Practice of Oral History*, eds. Sherna Berger Gluck and Daphne Patai. London: Routledge.

Pateman, C. 1988. *The Sexual Contract*. Oxford: Polity Press.

Piore, Michael and Charles Sabel. 1984. *The Second Industrial Divide: Possibilities for Prosperity*. New York: Basic Books.

Pocock, Barbara. 1988. *Demanding Skill: Women and Technical Education in Australia*. Sydney: Allen and Unwin.

Porter, Sam. 1992. Women in a women's job: the gendered experience of nurses. *Sociology of Health and Illness* 14, no. 4 : 510-527.

Preston, Valerie, Damaris Rose, Glen Norcliffe and John Holmes. 2000. Shift Work, Childcare and Domestic Work: Divisions of Labour in Canadian Paper Mill Communities. *Gender, Place and Culture* 7, no. 1 (March): 5-29.

Ransome, Paul. 1999. *Sociology and the Future of Work: Contemporary Discourses and Debates*. Aldershot: Ashgate.

Reverby, Susan. M. 1990. The Duty or Right to Care? Nursing and Womanhood in Historical Perspective. In *Circles of Care: Work and Identity in Women's Lives,* eds. Emily. K. Abel and Margaret. K. Nelson. U.S.A: State University of New York Press.

Ribbens, Jane and Rosalind Edwards eds. 1998. *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives.* London: Sage Publications.

Savage, Mike and Anne Witz. eds. 1992. *Gender and Bureaucracy.* Cambridge: Blackwell.

Scott, Gary. 1995. *Place Struggles: A Critical Analysis of Changing Patterns of Work, Unemployment, and Local Development in New Zealand and the West Coast of the South Island.* Unpublished PhD Thesis. New Zealand: University of Canterbury.

Scott, Joan. W. 1992. Experience. In *Feminists Theorize the Political,* eds. Judith Butler and Joan Scott. New York: Routledge.

Serron, Carroll and Kerry Ferris. 1995. Negotiating Professionalism: The Gendered Social Capital of Flexible Time. *Work and Occupations* 22, no. 1 (February): 22 - 47.

Shields, Rob. 1991. *Places on the Margin: Alternative Geographies of Modernity.* London: Routledge.

Simon, Barbara-Levy. 1990. Impact of Shift Work on Individuals and Families. *Families in Society* 71, no. 6 (June): 342-348.

Smith, Barbara. 1972. Letter to the Editor. *New Zealand Nursing Journal: Kai Tiaki.* (October): 7.

Smith, P. 1992. *The Emotional Labour of Nursing.* London: Macmillan.

Soja, E. 1989. *Postmodern Geographies: The Reassertion of Space in Critical Social Theory.* London: Verso.

Soja, E. 1995. Heterotopologies: A Remembrance of Other Spaces in the Citadel-LA. In *Postmodern Cities and Spaces,* eds. S. Watson and C. Gibson. U.K: Blackwell.

Somers, Margaret. 1994. The Narrative Constitution of Identity: A Relational and Network Approach. *Theory and Society* 23, : 605-649.

Statistics New Zealand. 1998. *New Zealand Now: Women.* Wellington: Ministry of Women's Affairs.

Sturdy, Andrew, David Knights, and Hugh Willmott eds. 1992. *Skill and Consent: Contemporary Studies in the Labour Process.* London: Routledge.

Sturdy. Andrew. 1992. Clerical Consent: Shifting Work in the Insurance Office. In *Skill and Consent: Contemporary Studies in the Labour Process,* eds. Andrew Sturdy, David Knights and Hugh Willmott. London: Routledge.

Thornley, C. 1996. Segmentation and Inequality in the Nursing Workforce: Re-evaluating the evaluation of skills. In *Changing Forms of Employment: Organisations, Skills and Gender,* eds. Duncan Gallie, Rosemary Crompton and K. Purcell. New York: Routledge.

Tolich, Martin and Carl Davidson. 1999. *Starting Fieldwork: An Introduction to Qualitative Research in New Zealand.* New Zealand: Oxford University Press.

Traynor, Michael. 1999. *Managerialism and Nursing: Beyond Oppression and Profession.* London: Routledge.

Waerness, Kari. 1992. On the Rationality of Caring. In *Women and the State: The Shifting Boundaries of Public and Private,* ed. Anne Showstack Sasson. First edition: 1987. U.S.A: Unwin Hyman Ltd. Reprinted 1992. London: Routledge.

Wajcman, Judy. 1996. Women and Men Managers: Careers and Equal Opportunities. In *Changing Forms of Employment: Organisations, Skills and Gender*, eds. Rosemary Crompton, Duncan Gallie and Kate Purcell. Routledge: London.

Walby, Sylvia. 1986. *Patriarchy at Work: Patriarchal and Capitalism Relations in Employment.* Cambridge: Polity Press.

Walby, Sylvia, and June Greenwell with Lesley Mackay and Keith Soothill. 1994. *Medicine and Nursing: Professions in a Changing Health Service.* London: Sage Publications.

Walby, Sylvia. 1997. *Gender Transformations.* London: Routledge

Waring, Marilyn. 1988. *Counting For Nothing: What Men Value and What Women are Worth.* New Zealand: Allen and Unwin.

Weedon, Chris. 1987. *Feminist Practice and Poststructuralist Theory.* Oxford: Blackwell.

Wicks, Deirdre. 1998. *Nurses and Doctors at Work: Rethinking Professional Boundaries.* Buckingham: Open University Press.

White, Lynn and Keith Bruce. 1990. The Effect of Shift Work on the Quality and Stability of Marital Relations. *Journal of Marriage and the Family* 52, no. 2 (May): 453-462.

Wood, Stephen. 1982. *The Degradation of Work: Skill, Deskilling and the Labour Process.* London:Hutchinson.

Appendix A

Interview Schedule

Professional identity

Have you always wanted to be a nurse?

Did you train in the town?

How important is nursing to you?

Are you working as a nurse at the moment? In what capacity; that is, what area are you working in and are you full time, part-time or casual?

How long have you worked in the job that you are in at the moment?

Are you happy in your present job? Why? Why not?

Have you done any further nursing or related training since you finished you original training? If so, what did this consist of?

Do you get to practice the skills that you feel you have in your paid employment at the moment?

How do you keep up to date with advances in nursing? Is there any in-service education offered at the hospital?

Do you think that nursing has changed in say the last ten years?

In what way has it changed?

Has nursing changed in importance for you in the last ten years? Why?

What do you think of the changes at the hospital? Do you think that these changes have an impact on the way you practice as a nurse?

Location

Have you always lived in the town?

What ties do you have to the town?

What do you like about the town?

What do you dislike about the town?

How do you think being here affects your role as a nurse?

Would you be prepared to travel for work?

Would you be prepared to move for work?

Public/ Private

If you live with another adult, who is the primary breadwinner?

If you have children how are they cared for while you are at work?

Do you work as much as you would like to?

What is the most important thing about paid work for you?

Appendix B

Research Project Information Sheet

University of Canterbury

The Professional Identity of Nurses in one New Zealand Town Under the Health Reforms

Researcher: Lee Thompson
MA Thesis Writer, Department of Feminist Studies
University of Canterbury
Phone: University (03) 366 7001 ext 8203
Home (03) 377 2902

Supervisor: Dr Nabila Jaber
Department of Feminist Studies
University of Canterbury
Phone: (03) 364 2702

You are invited to take part in a research project focusing on the experiences of nurses in your town.

I am interested to look at how you perceive your job as a nurse and how your job may have been affected, either negatively or positively by the successive processes of reform in the health sector

I am interested in you perceptions of the town and how this geographic location may influence your employment choices.

I am also interested in how your role as a nurse shapes, or is shaped by your role as a partner/wife, mother or father (if you are one), and how you negotiate the boundary between home and paid work.

If you agree to participate in this study, you will be asked to meet with myself, Lee Thompson, for an interview of about one hour. This interview will take place at a time and place convenient to you, and will be tape recorded and transcribed. As a follow up to the interview I will send you the transcript of the interview. This will enable you to check that your comments have not been misrepresented unintentionally and also you may wish to delete or point out areas where you feel that you may be identified by what you have said. Is very important to me that your words are not misrepresented and that confidentiality is maintained.

If you take part in the study you have a right to:

a) Refuse to answer any particular question, and to withdraw from the study at any time.

b) Ask further questions about the study that occur to you during your participation.

c) Provide information on the understanding that it is completely confidential to the researcher, and that you will not be identified in any reports that are prepared from the study without prior consent.

d) Examine the transcript of the interview, amend details which may compromise confidentiality, and indicate any part of the transcript that you do not wish to be used.

e) Be given access to a report of the findings from the study when it is completed and published.

f) Determine the disposal of the interview tapes, transcripts of interviews, and personal documents made available to the researcher.

Information collected during this project will be used as the basis for my MA thesis at the University of Canterbury. I will summarise the findings in a report and will possibly submit this for publication in an academic journal, or present the findings at a conference.

I hope that you will agree to participate and that you will find the experience useful. Please feel free to contact me, or my supervisor Dr Nabila Jaber if you require further information.

The project has been reviewed and approved by the University of Canterbury Human Ethics Committee.

Appendix C

CONSENT FORM

The Professional Identity of Nurses in One New Zealand Town Under the Health Reforms

Researcher: Lee Thompson
MA Thesis Writer, Department of Feminist Studies
University of Canterbury

I have read and understood the description of the above-named project. On this basis I agree to participate as a subject in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information that I have provided.

Signed..... Date.....

Appendix D

Competencies for Entry to the Register of Nurses

Evidence of safety to practise as a registered nurse is demonstrated when the applicant meets the performance criteria for the 11 competencies listed below and further detailed on the following pages.

1.0 Communication
Relates in a professional manner and communicates effectively to support the client through the health care experience.

2.0 Cultural Safety
Practises nursing in a manner which the client determines as being culturally safe.

3.0 Professional Judgement
Makes professional judgements that will enhance nursing practice.

4.0 Management of Nursing Care
Manages nursing care in a manner that is responsive to the client's needs, and which is supported by nursing knowledge.

5.0 Management of the Environment
Promotes an environment which maximises client safety, independence, quality of life and health.

6.0 Legal Responsibility
Practises nursing in accord with relevant legislation and upholds client rights derived from that legislation.

7.0 Ethical Accountability
Practises nursing in accord with values and moral principles which promote client interest and acknowledge the client's individuality, abilities, culture and choice.

8.0 Health Education
Assists clients and groups to achieve satisfying and productive patterns of living through health education.

9.0 Interprofessional Health Care
Promotes a nursing perspective within the interprofessional activities of the health team.

10.0 Quality Improvement
Contributes to ongoing quality improvement in nursing practice and service delivery.

11.0 Professional Development
Undertakes responsibility for own professional nursing development and contributes to the development and recognition of professional nursing practice.

Nursing Council of New Zealand *Competencies for Entry to the Register of Nurses,* April 1999.